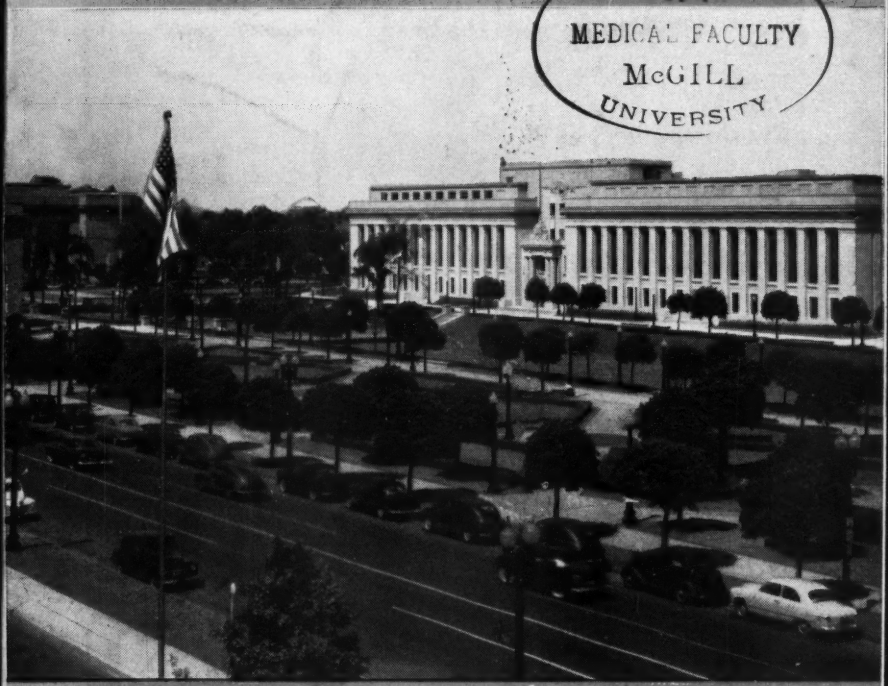
Oral Hygiene

MAY 1954

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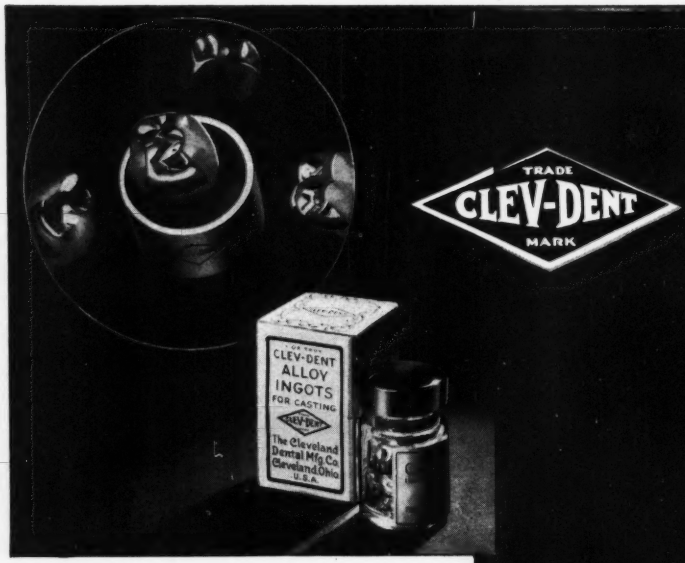


World War I Memorial with new American Legion Headquarters, Indianapolis, Indiana. The Indiana State Dental Association meets May 17 to 19 at Indianapolis.

In this issue:

SO YOU WANT SOCIAL SECURITY?

MAY 11 1954



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Inlays made from CLEVE-DENT ALLOY INGOTS while hard are also sufficiently ductile to allow the margins to be burnished. They take a brilliant, long lasting polish.

The technic of using these ingots for an inlay is the same as that for a gold inlay except that they melt at a much lower temperature.

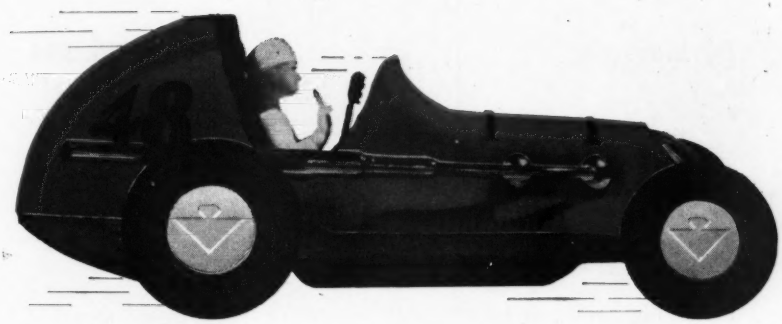
A non-oxidizing, soft flame without too much air is recommended for melting. Overheating may cause some of the lower melting metals to be burned out of the alloy.

60 years of service to the profession.

The Cleveland Dental

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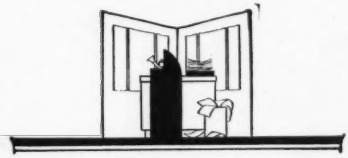
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The Publisher's CORNER

By Mass



No. 394

Are You a Poached Egg?

HERE IN THE CORNER, you sit surrounded by bookcases, battered old ones. They are loaded with bound volumes of our magazines—forty-three years of ORAL HYGIENE, for example; twenty-four years of *Spanish Oral Hygiene;* and thirty-six years of *Proofs, The Dental Trade Journal.* That one is sort of an ORAL HYGIENE for dental supply people. There's not room in here for all the fifty-nine volumes of *Dental Digest.*

There's another title. A lone volume cowers in a dark corner of the shelves—as it should. That one is *Good Hardware.* It represents a nine-month effort in 1920 to bust into the hardware industry. It was a good try, but we nearly lost our shirtsy-wirtsy.

Bound volumes are always rather fascinating to anyone who has had anything to do with putting them together. But they are also a record of your dopey moments when you wrote stuff which you should have mislaid before the printer got hold of it.

Still, here and there you find some old stuff that still sounds pretty good—not bad, anyway. For example, this twenty-five-year-old quote from *Proofs, The Dental Trade Journal.* Who knows but what this 1929 job may help to soothe your soul in 1954:

"Frequenters of lunatic asylums," says Arnold Bennett, "are familiar with the person who, being convinced that he is a poached egg, continually demands to be put on hot toast, and is continually unhappy because nobody will put him on hot toast.

"This man is quite harmless; he is merely a bore by reason of a

A delectable aid to dental health



The good you accomplish at your chair is frequently undone by today's soft, refined diet. A fresh juicy apple after meals is a tasty aid to conservation of dental health. The apple is a succulent cleanser, of natural efficacy, convenient and enjoyable. Its firm chewable texture gives needed massage to flabby gums. Its delicate aroma and lively flavor stimulate the salivary glands to copious secretion. These benefits are obtainable in greater measure from the enjoyment of apples than in any other way. A recommendation of apples after meals is one whose merit your patients will promptly substantiate by conscious experience.

***NEW** film "Gateway to Health" in 16mm. color and sound. Case histories from practice of Fred D. Miller, D.D.S., Altoona, Pa., demonstrate influence of dietary habits on dental health. Especially suitable for professionally sponsored public education programs. Write to address below.*

NATIONAL APPLE INSTITUTE, 726 JACKSON PLACE, N. W., WASHINGTON 6, D. C. *in behalf of*

THE APPLE GROWERS OF AMERICA

ridiculous delusion about the fulfilment of his true destiny being bound up with hot toast."

We all of us are poached eggs at times, unhappy because we cannot accomplish some end ardently regarded as absolutely vital to our happiness.

The best proof that many of our most fervent yens are nothing to get fervent about is the speed with which we lose interest once each such yen is satisfied.

Years and years go, Elbert Hubbard's old *Philistine* carried on its back cover a picture of a singing bird, perched upon a blossoming bow—a careless looking bird, singing just for the joy of it. The legend was "It really doesn't matter."

And while perhaps the dental business would go to the dogs if we all lived by that happy bird's rule, I think it's true enough that often we could avoid being poached eggs by realizing that maybe it really doesn't matter after all if we don't get everything we think we want.

More than once, I have seen men curdle their corpuscles fighting for objects which weren't worth the effort. The trouble is, the desire to *get* can become so strong that one doesn't stop to meditate upon the real value of the prize.

I have seen men scheme and connive to get something, only to find it a burden and a nuisance. Yet, at the time, even life itself seemed to depend upon their getting this very special toast to sit on.

A couple of years ago I read an article by an Englishman whose name I have forgotten. He worked out a philosophy for himself that had to do with avoiding the burden of material possessions. He worked out the shelter problem, for example, by providing quarters for himself that were no more, and no less, than he needed for comfort. He dispensed with all the accumulation of fancy truck that most of us think we need.

He found that, after all, we don't need much in the way of material possessions, for serenity and happiness.

Even an extra fountain pen is something to inventory and to guard, he figured; in his philosophy one was burdened by any possession beyond the ordinary necessities and ordinary comforts of life.

Maybe he cut it pretty fine. I don't know. But, anyway, with money enough to buy a great deal more, he did find happiness just through not being obliged to administer possessions beyond the things he used each day.

Which is something to think about as we poached eggs dart fretfully about seeking toast to sit on.

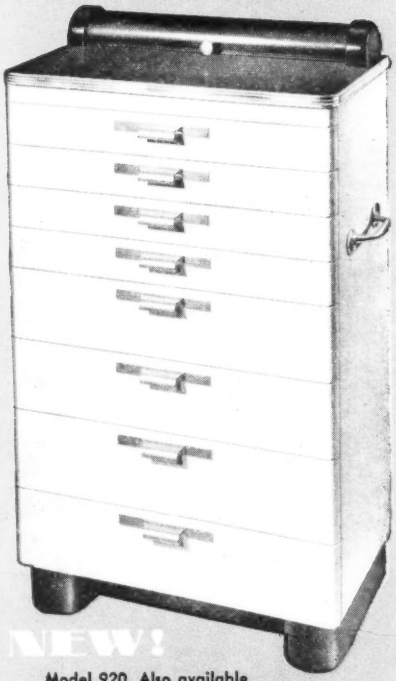
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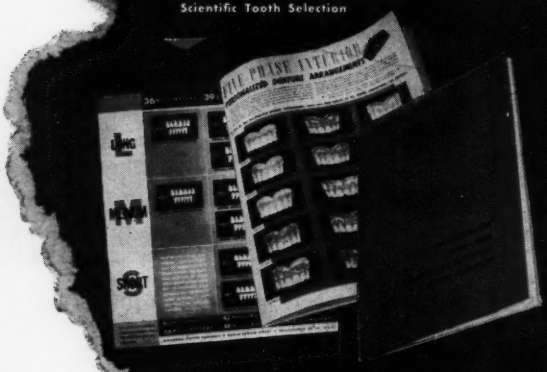
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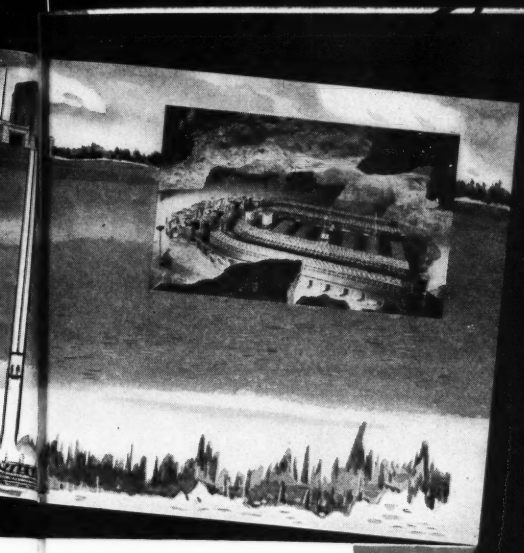
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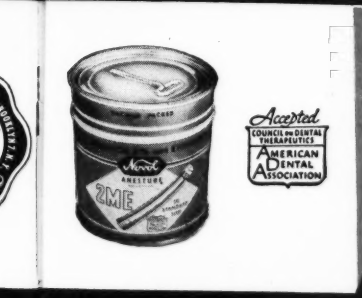
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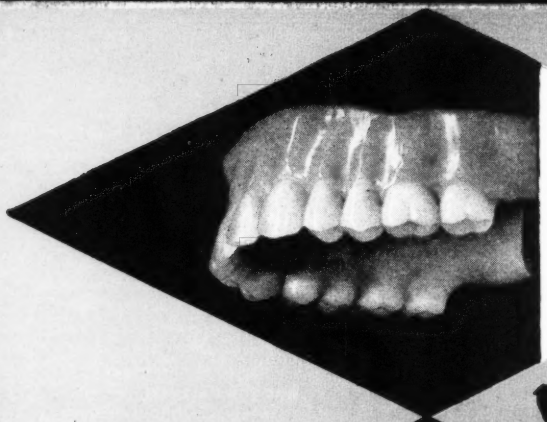
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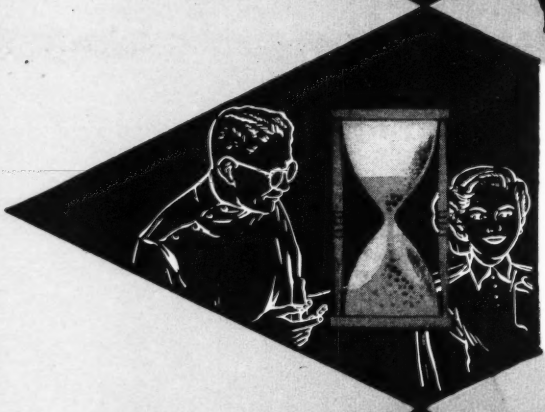
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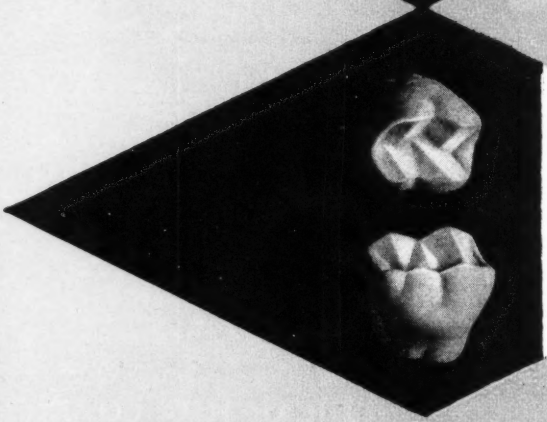


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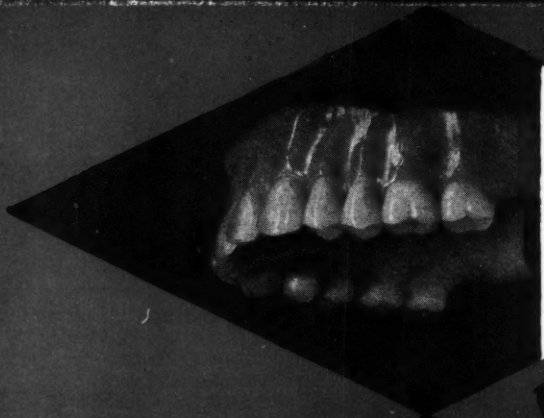


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material proven
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clinical use



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occlusal forms
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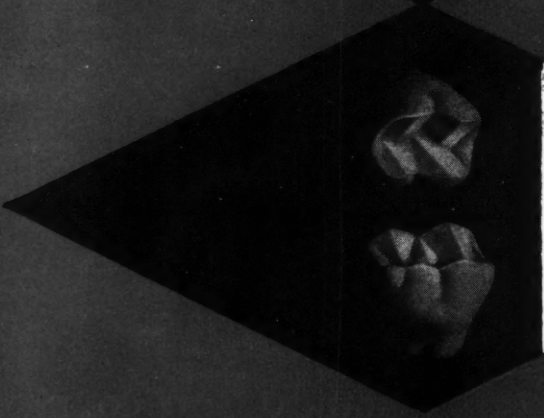


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- Synchronized occlusal forms eliminate tripping (which does double damage by trauma to tissue and excessive wear of teeth).
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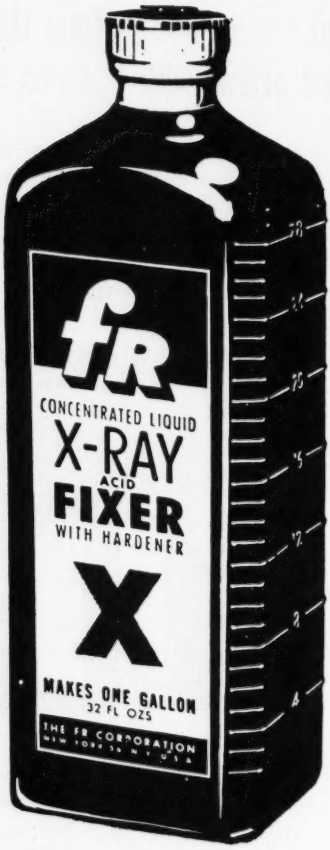
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Prove to yourself that Durallium "54" restorations are different . . . *better!* Your qualified Durallium laboratory will supply you.

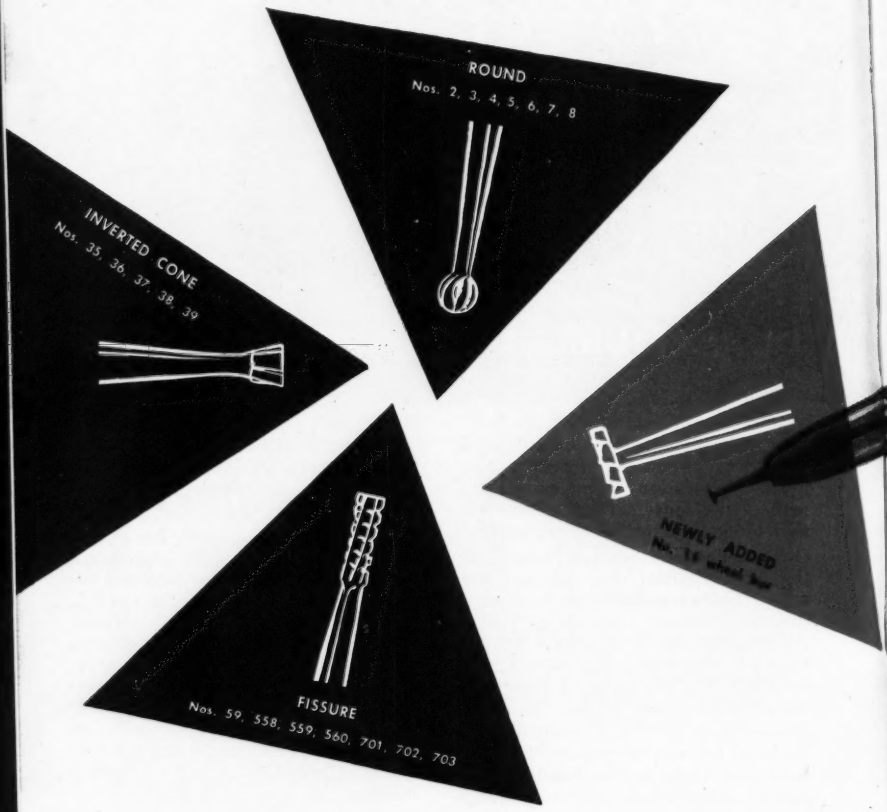
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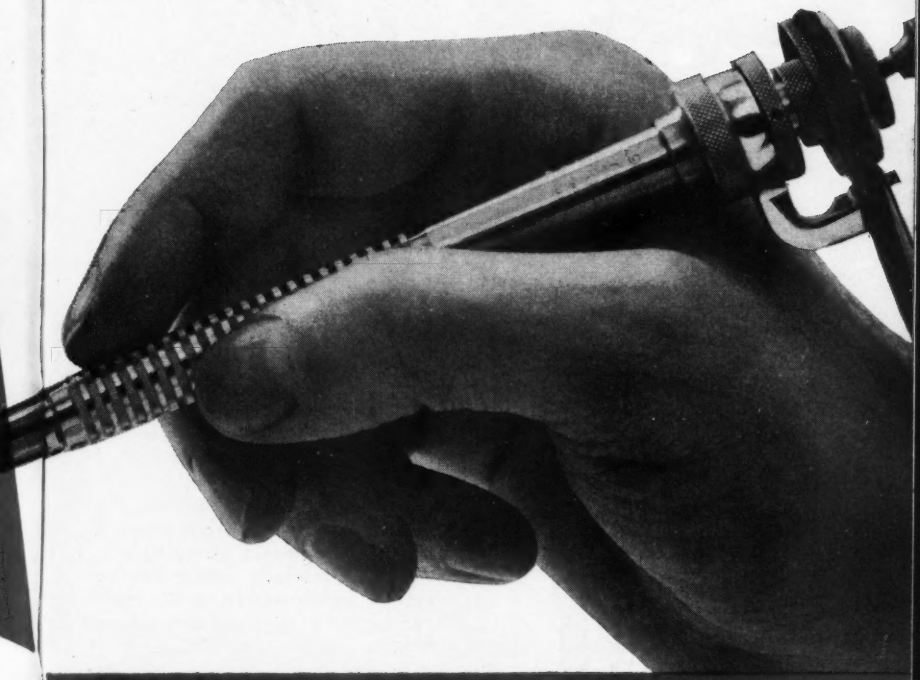
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To meet the growing demand for carbide burs, the S. S. White line now includes these sizes: Round burs, Nos. 3, 5, 7. Inverted Cone Burs Nos. 36, 38. Dentate Bur No. 560.

ANOTHER FIRST

No. 14 carbide wheel bur designed for fast, accurate slot cutting. Made of the highest grade American tungsten carbide—as are S. S. White Carbide Burs in every size.

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Novice denture patients, too, find it expedient to take precautions to help assure the stability and retention of their dentures, until adequate practice overcomes their initial awkwardness.

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MAY 1954

Hypnotic phenomena were known thousands of years ago to the Persian magi and Indian yogis, but medical interest in the subject was not generally stimulated until the latter half of the 18th century by the work of Mesmer, a Viennese physician. Not only has hypnotism since been highly fruitful in adding to our knowledge of normal and abnormal psychology, but its present application to such fields as dentistry is increasing. Hypnosis is reportedly used by about 2,600 dentists in the U.S.A. today, with a conservative estimate of 75,000 inductions annually.

• • •

Dental journals preserve the living record of dentistry in the making. Yet journals themselves die. Among those in the English language that are no longer published, but whose volumes contain valuable reference material, are: The American Journal of Dental Science (1839-1860); Dental Register (1847-1923); Dental Review (1886-1918); Journal of the Allied Dental Societies (1906-1918); and Dental Cosmos (1859-1936).

• • •

It seems incredible, that it should ever have been considered expedient to expect large numbers of men to forego the availability of dental service for long periods of time—as for instance armies in field. Yet it wasn't until World War I that the practical value of military dentistry began to win recognition, leading one army surgeon to remark, "I will never go to war again without a dentist!"

• • •

The possibility of hearing through the teeth was first suggested about 1550 by Hieronymus Cardanus, a physician of Pavia. His theory that sound could be conducted to the brain via a stick of hard wood held firmly between the teeth was used by Beethoven, when he tried out his compositions on the piano. In 1928, a U.S. patent was granted to J. M. Cone for his dentiphone, which conveyed sound through a metal rod to the teeth; but this avenue of research has been superceded by modern electro-acoustic instruments.

• • •

One rarely thinks of India as a country of forests; yet over 20% of its land area is covered by luxuriant forest growth. Not the least important of the forest products yielded by these areas is gum karaya, which is exported to this country to provide (among other things) the basic ingredient for Wernet's Powder.

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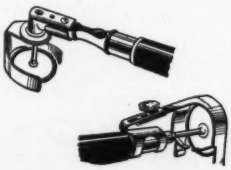
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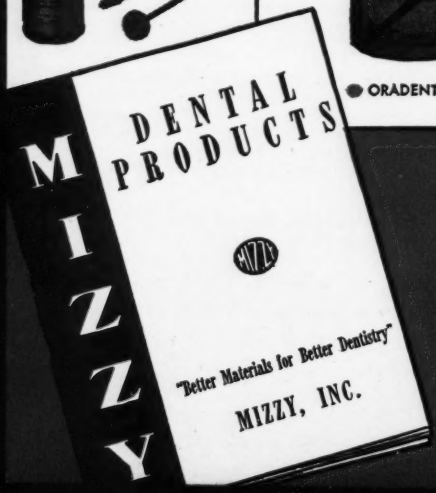
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Amion protects your patients in three significant ways:

1. Inhibits acid-forming bacteria.
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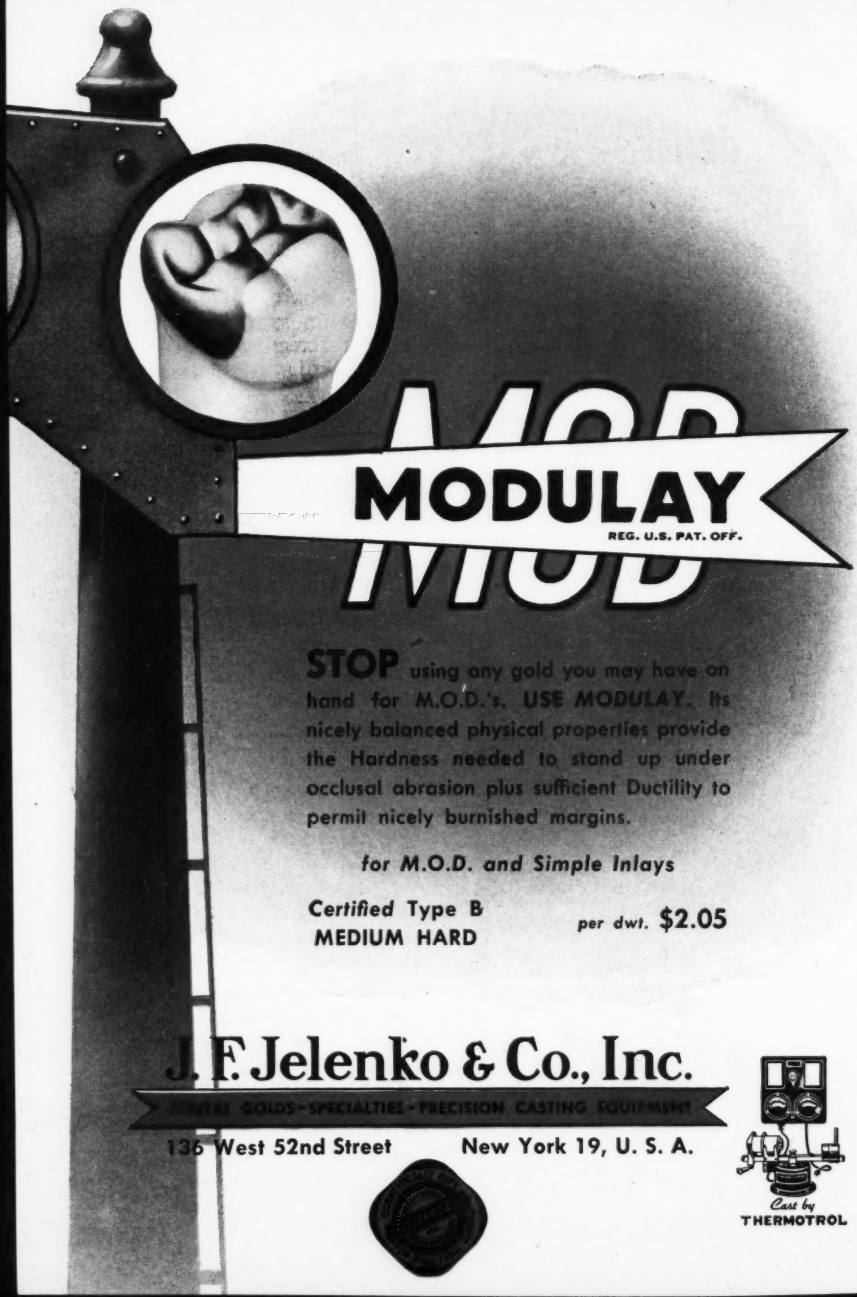
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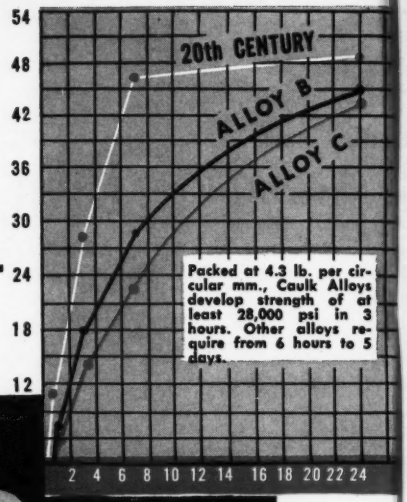
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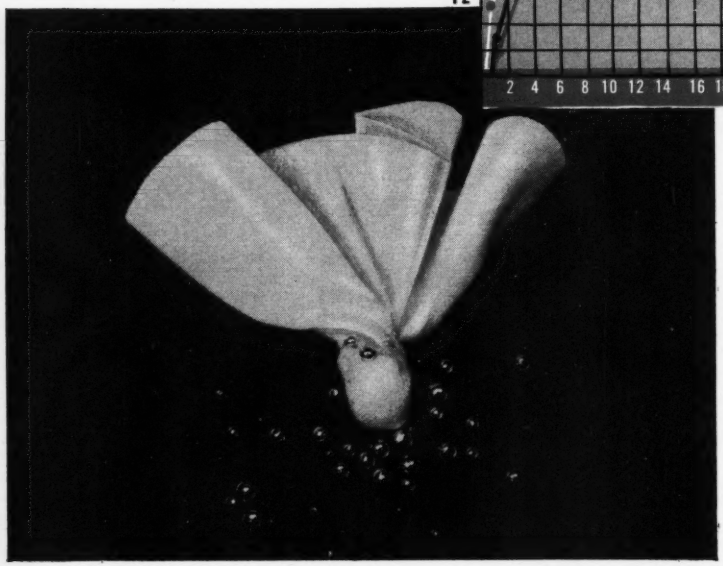
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EDITORIAL OFFICE: 708 Church Street, Evanston, Ill.; PUBLICATION OFFICE: 1005 Liberty Avenue, Pittsburgh 22, Pa.; Merwin B. Massol, Publisher; Robert C. Ketterer, Publication Manager; Dorothy S. Sterling, Promotion Manager; Homer E. Sterling, Art. NEW YORK: 7 East 42nd Street; Stuart M. Stanley, Vice President-Eastern Manager. CHICAGO: 866 Peoples Gas Building; John J. Downes, Western Manager. ST. LOUIS: Syndicate Trust Building; Carl Schulenburg, Southern Manager. LOS ANGELES: 1709 West 8th Street; Don Harway, Pacific Coast Manager. Copyright, 1954, Oral Hygiene, Inc. Publishers of Spanish Oral Hygiene, Dental Digest, and Proofs. Member of Business Publications Audit of Circulation, Inc. and National Business Publications, Inc. Printed in U.S.A.

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THE *"new look"* IN DENTURES

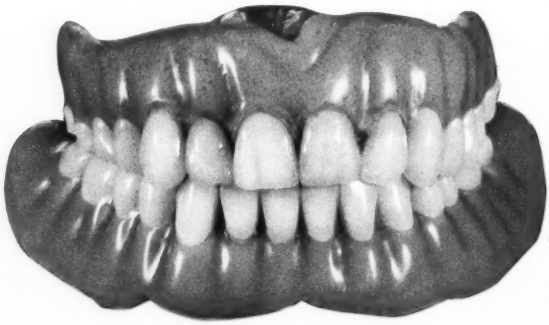
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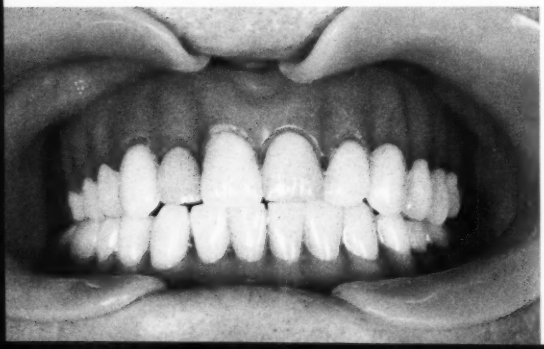
. . . Amazingly Natural Simulation of Living Tissue Color

. . . The Lifelike Forms and Beautiful Qualities of Healthy Natural Teeth

THE CONVENTIONAL DENTURE



RIGHT: An average conventional denture. Note the monotone appearance of the denture base material and the artificiality of the gum contouring.

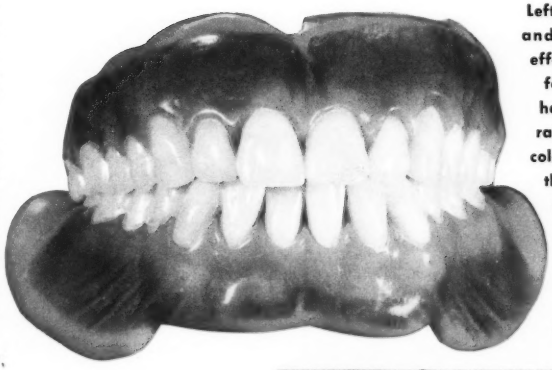


LEFT: The same case as above, shown in the mouth of the patient. Note again the lack of naturalness in the contouring, and the monotony of coloring which literally advertises its own artificiality.

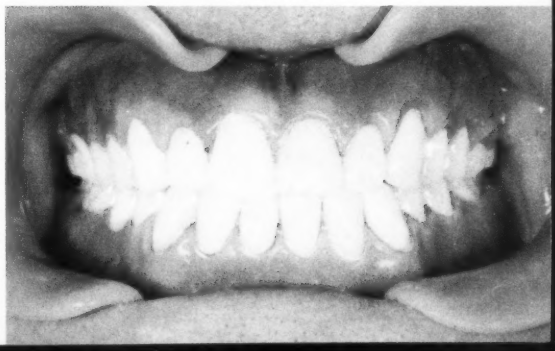
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Left: Trubyte Denture Veneers and Trubyte Bioform Teeth effected this radical change for the same patient. Note how the color veneer accurately reproduces the natural color of the living tissue, and the contour veneer supplies the natural anatomical form. Trubyte Bioform Mould 42F was used for the centrals and cuspids, 44E for the laterals; Shades B68 and B70.



RIGHT: The Trubyte Bioform Veneer Denture shown above, as worn in the mouth by the same patient, is hard to distinguish from a typical healthy natural dentition.

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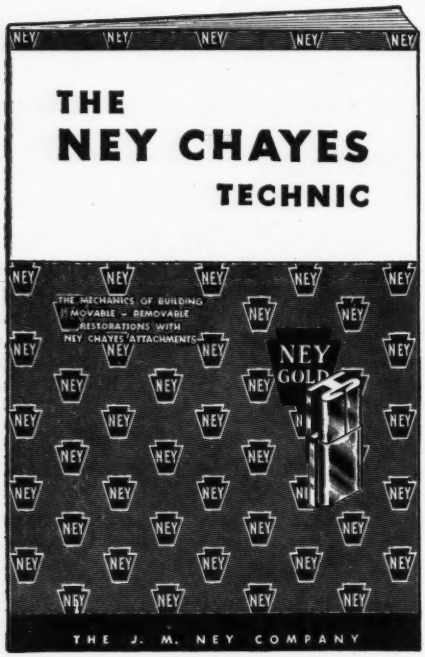
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Picture of the Month



A PITTSBURGH couple, Doctor and Mrs. Kenneth E. Krugh, are the parents of nine boys, enough for a baseball team. According to statistics, it is unusual for a family to have nine children all of the same sex. Pictured above is the whole Krugh family: Standing, left to right, John, 12; Kenneth Jr., 15; Mrs. Krugh with Robert, 13 months; twins, Charles F. and Andrew, 14; Doctor Krugh with Edward, 6. Kneeling, left to right, Thomas, 10; James, 9, and David, 2.—*Photograph courtesy of The Pittsburgh Press.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

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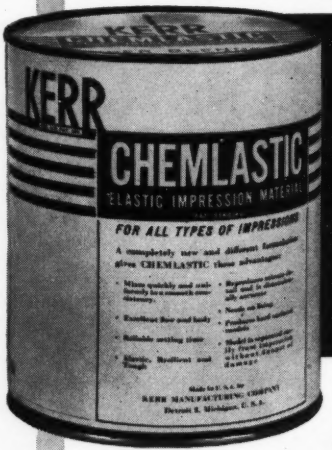
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Social Security?

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BY PHILIP PARKER, D.D.S.

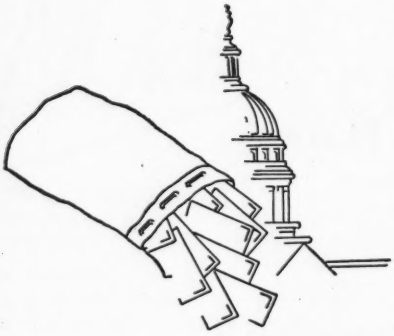
A 65-YEAR-OLD dentist retired from practice some time ago with $100,000. He was able to do this because of a lifetime of faithful devotion to his patients, his prodigious industry, his business acumen, and the death of an uncle who left him $99,250.

In the absence of such a fortuitous circumstance the chances are that you as well as your wife will need and welcome Social Security checks when you reach the age of 65. That is mainly due to the fact that "the years of the advantageous practice of a dentist are comparatively few," according to the late C. Edmund Kells.

Sir Andrew Clark, a prominent medical internist, once said that he "had striven ten years for bread, ten years for bread and butter, and twenty years for cake and ale." That is really a good partition of the life of a dentist except that many of us do not reach the last stage or having reached it do not remain there long.

"The years of the advantageous practice of a dentist are comparatively few."

In their heyday dentists do not toss their money away in riotous living, but they do strive to give their children an education comparable to their own. This and the dry-bread decades result in a situ-



ation where the dentist has little capital in the bank when he reaches three score and five. That is why most dentists, speaking privately or when polled, are in favor of Social Security coverage.

And yet, the House of Delegates at the Cleveland meeting of the American Dental Association voted 312 to 64 against Old-Age and Survivors Insurance. These delegates are informed, intelligent and warmhearted human beings. Why did they sell the rank and file down the river? Simply because they have lost the common touch with their fellow men. This is a frequent occurrence in every facet of society.

Frank W. Abrams, Vice-President of the Standard Oil Company of New Jersey, has said:

"Most of the people I know in high positions not only were born barefooted, but many of them stayed that way for some time. But it is true—and I think we can see it everywhere—that as success comes and men rise to positions of responsibility, they start going to the same clubs, talking to each other, playing golf in the same foursome, making speeches to each other, and generally building up a wall around themselves."

Thus there is cause for regret but none for surprise at the vote of our delegates. It is an old truism that in prosperity our equanimity is chiefly exercised in enabling us to bear with *composure the misfortunes of our neighbors.* All of which brings me to an intimate question that I have been reluctant to raise in public: When the delegates voted against Social Security, did they vote before or after dinner?

Dental Aristocracy

Our trouble stems from the fact that we have set up what might be called an aristocracy within the profession. It is time for a change. Our leaders should leave their ivory towers and become reacquainted with the "folks" if they are to know their aims and aspirations. That is the only way they can re-establish themselves in our minds as seekers of our interest.

In its appeal for the Relief Fund the American Dental Association says that "the need is great" and yet, its delegates voted against OASI. Dentists do not want charity; they want *prepaid security.* No dentist should be subjected to the indignity of relief status at the age of 65. All his life an active parti-

cipant in social life, he must not suffer the humiliation of voluntary withdrawal from society.

Dentists need Social Security coverage, but our House of Delegates who are supposed to represent us are opposed to it. Fortunately, we have a staunch champion in the President of the United States. On January 14, President Eisenhower proposed the coverage of physicians and dentists in the Social Security program. The President's proposals were included in bills submitted immediately by Congressman Daniel A. Reed, Chairman of the House Ways and Means Committee. Hearings on these bills will be held during the next few months before congressional committees.

While you are waiting for the American Dental Association to become more responsive to the needs of its members, here is what you can do. You can strengthen the hands of those who are trying to help you obtain Social Security coverage by writing them. You should write to Congressman Reed at Washington, D.C.

★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

THIS ARTICLE by PHILIP PARKER, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

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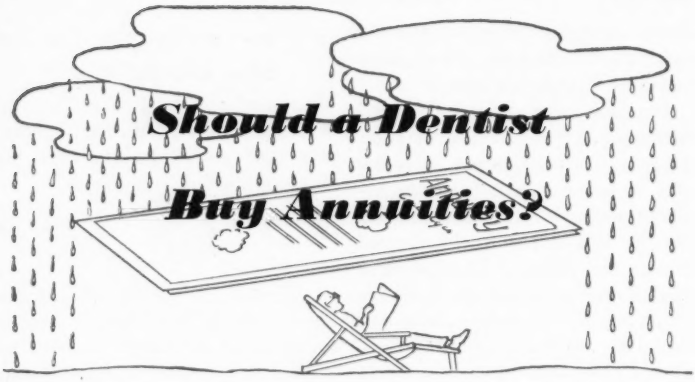
We still have too much complacency, or at any rate, a notable absence of articulate support for Social Security. If you really want it, you must make your voice heard. The action that you take now can well decide your destiny at the age of 65. To paraphrase Thomas Paine: "Those who expect to reap the blessings of Social Security, must like men, undergo the fatigue of supporting it."

Congressman Daniel A. Reed is as close as your nearest mailbox. The power of the individual American's "pen" is still paramount in this country. So, take your pen in hand and write now!

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THE COVER

PICTURED on this month's cover is the World War I Memorial, with the new American Legion Headquarters, at Indianapolis, Indiana. The Indiana State Dental Association will held its ninety-seventh annual meeting in that city May 17 to 19 in the Claypool Hotel. Detailed information about the program may be obtained from Doctor E. E. Ewbank, Secretary, Indiana State Dental Association, Box 96, Kingman, Indiana.



BY SIDNEY SCOTT ROSS

Different types of annuities fulfill the varying retirement needs of dentists.

SUPPOSE you are a dentist, aged 40. You have worked long and hard and now have a lucrative practice. But you want to make certain that you will have some permanent, fixed income after you reach age 60—whether you continue to work full-time, or begin to taper off a bit, or retire altogether at that time.

Under such circumstances you should consider buying an *annuity*, usually sold by life insurance companies, which provides that you, the *annuitant*, will receive a fixed sum of money periodically for as long as you live.

There are many types of annuities available. One of the most popular, particularly with professional people, is the *retirement* annuity, which can easily be adapted to fit the needs and circumstances of the dentist described here.

You can buy a retirement annuity with a single premium, in one lump sum, usually some multiple of $1000, but this may not be feasible or practical. Most dentists find it easier to pay premiums annually, in units of $100.

Usually no medical examination is required to buy an annuity, but you must produce some proof of your age.

If you die before receiving your first income check on your retirement annuity, the insurance company will pay your beneficiary a death benefit, or the total amount of all premiums paid in, whichever is greater.

However, keep in mind that should you buy a retirement an-

nuity and discontinue paying premiums a few years later, you will receive an amount which is less than the total of all the premiums you have paid.

The retirement annuity is a flexible contract. A dentist who wishes to receive income payments earlier or later than the age specified in the contract should notify the insurance company, and the change will be made, provided he does so *before* he reaches this specified age.

Consider the case of another dentist, aged 60 or 65 or more, who has accumulated a substantial sum of money and is ready to retire. This man is in good health, he has no dependents, or has already provided for them through other means. This dentist has a real problem deciding how much he can afford to spend in each of his remaining years. He may outlive his capital if he lives to a ripe old age. If he dies only a short time after retirement and spends too little, he is depriving himself of many joys and luxuries his money could have provided.

A *straight life* annuity is indicated for this dentist, who pays a single premium in a lump sum. He starts receiving income checks immediately, every month, every three months, every six months, or every year, after the date of purchase.

A straight life annuity has no cash value. If the dentist pays in a substantial sum to the insurance company and dies after receiving only a few income checks, there is no death benefit payable to his beneficiary.

Refund Annuities

To meet objections to this gamble, insurance companies offer *refund* annuities, which provide that the annuitant receives regular income payments during his lifetime. But when he dies, if the total income he has received is *less* than the *purchase price* of the annuity, the *difference* or *balance* is paid to the beneficiary. (If the income received is *more*, the beneficiary gets nothing.)

When the balance is paid to the beneficiary in installments, the plan of payment is called the *installment refund* annuity. If the balance is paid to the beneficiary in a lump sum, this plan is known as the *cash refund* annuity. If the balance is paid for a designated number of years, say ten or twenty, even if the annuitant has not lived that long, the plan is called an *installments certain* annuity.

Another type of annuity, called the *joint life and survivorship* annuity, may appeal to the dentist if his wife is still living when he retires. An income is paid for life to both husband and wife. When one of them dies, the income continues to be paid to the survivor until his or her death. Some contracts call for the same income throughout. Others provide for a reduction of income at the death of one spouse,

since living expenses for one person are less than for two.

An annuitant receives favorable Federal income tax treatment. Suppose an elderly dentist buys an annuity for $50,000, on which the income is $3500 per year. Only 3 per cent of the $50,000, or $1500, is considered taxable income. This dentist therefore pays a tax on only $1500. The remaining $2000 will be tax-exempt each year for the next 25 years—($50,000 divided by $2000).

Freedom From Worry

In addition to this tax advantage, the dentist will not have to spend time selecting proper investments, and worrying whether he has made a wise choice. This freedom from financial cares and worries must be a comforting feeling, because elderly persons who buy annuities seem to live far longer than average, according to some life insurance physicians.

However, do not lose sight of the fact that annuities possess some serious limitations and disadvantages. Should living costs continue to rise and the purchasing power of the dollar decline, the annuitant would be seriously affected in exactly the same way as owners of other fixed income securities—such as bondowners, and savings bank depositors.

Also bear in mind that each time you receive an annuity income check, this represents not only interest but also a return of your principal, thus cutting down on the amount you can leave to your beneficiary or estate. Because people are living longer each passing decade, the trend is for life insurance companies to increase premium rates on annuities.

For these reasons, *before* buying an annuity, be sure to consult a reliable, competent experienced financial or insurance adviser, to determine whether an annuity is suitable for your requirements and circumstances, and if so, which type should be purchased.

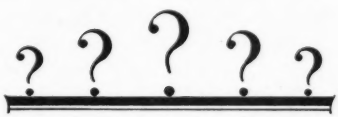
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New York 67, *New York*

STRAIN IN PRACTICE CAN BE REDUCED

It is paradoxical that the members of the dental profession, engaged in the preservation of the oral health of the American public, neither as individuals nor as a profession, make any adequate attempts to conserve their own physical and mental resources.

Four adjuncts to dental practice, which can materially reduce physical exertion and mental strain are (1) the dental assistant, (2) the dental operating stool, (3) adequate office lighting, and (4) a preoperative sedative.—*Journal of the American Dental Association,* November, 1953.

So You Know Something About DENTISTRY!



CXVI

1. Why does the alveolar bone have a lower threshold to nutritional diseases than other bones? _____

2. Leucocytosis is (a) a decrease, (b) an increase, in the number of polymorphonuclear leucocytes circulating in the blood. _____

3. What is secondary occlusal trauma? _____

4. Retention of full dentures depends on (a) atmospheric pressure, (b) viscosity of saliva, (c) interface tension. _____

5. How does the body compensate for the wear of the teeth? _____

6. The hemostatic action of oxidized cellulose is (a) greatest, (b) least, when the dry material is applied. _____

7. True or false? In general, the setting expansion of the investment is effective in compensating for gold alloy shrinkage. _____

8. Chilling a tooth containing a resin will cause the filling to shrink almost (a) 2, (b) 4, (c) 10, times more than the tooth. _____

9. Does dry socket follow extraction of pulpless teeth more frequently than it does vital teeth? _____

10. True or false? One of the important factors in the etiology of dental caries is the inherent pattern of tooth development —it determines caries susceptibility and non-susceptibility. _____

FOR CORRECT ANSWERS SEE PAGE 646



Doctor Robert Emmett Motley 66-year-old Washington, D.C., dentist, is pictured above roller skating with Miss Ann Morgan, one of his patients. The dentist learned to skate four years ago and as an outgrowth of this interest, he was inspired to take lessons on the organ, the roller rink rhythm maker.—Photograph by Adolph More.

Roller Skating Dentist!

BY HENRY FANKHAUSER*

IT IS never too late to learn is the philosophy of Doctor Robert Emmett Motley, a dentist in the Washington, D.C., area for the past 30 years. His interests outside office hours range from canning honey to playing the organ. His most enthusiastic accomplishment of recent years has been learning to roller skate.

Doctor Motley is 66 years old and started his skating venture four years ago. He is acclaimed as the oldest active roller-skater around the Washington area, which includes outlying communities of nearby Maryland and Virginia. He is in a class by himself when it comes to skating. He whisks around the rink in feather-like fashion for a man of his husky build and ripening age.

*Staff writer, Washington Daily News.

Art, floriculture, music, handicrafts, skating—these are some of the hobbies versatile Washington dentist enjoys.

The dentist remembers the day four years ago when two young neighbors approached him, skates in hand, and jokingly urged him to go roller-skating with them. He did not go that day; but the next evening, to prove to them he was game, he traveled to one of Washington's favorite rinks to try his luck on skates.

Doctor Motley had been dieting at the time, and after losing nearly thirty pounds had discovered new energy. To his amazement, during that first try on skates he performed quite well. By the following evening Doctor Motley had purchased a pair of his own.

On his first few visits no one would have anything to do with him. The children wanted to know what "an old fossil" like him was doing around a roller rink. Roller-skating was a sport limited to the younger generation, they thought.

The dentist entered skating classes to learn the secrets of successful skating, and soon could perform the bronze dance steps almost to perfection and twist into the difficult three turns and backward turns.

He became a familiar figure around the rink, almost as familiar as with his patients at the Farragut Medical Building where he has practiced dentistry for the past 30 years. He will never forget the little boy who came up to him one evening at the rink and asked, "Doctor Motley, do you live here?"

The roller rink environment gave Doctor Motley a desire to play the organ, the roller rink rhythm maker.

"Its rhythmic and deep tones inspire me when I am out there skating," he says, "I just had to learn to play it." He used to strum on the guitar a bit in his youth while attending the University of Michigan, but that was the extent of his music making until 18 months ago when he persuaded the organist at the arena to give him instructions on the instrument.

Owns Organ

Doctor Motley could not read a note of music a year and a half ago. Now he has even purchased a $3,500 organ and can play almost any popular tune.

When the dentist undertakes a new hobby he is not content with just learning the fundamentals. He has to know its history and everything about it. That is just what he did after starting to play the organ. He will tell you the principle on which the instrument plays, draw diagrams to explain further its operation and while doing this give you a complete biography of the inventor of the instrument.

Doctor Motley has been tempted to ask the manager of the roller

rink to let him perform at the organ one night—or even for a matinee performance. It would be a coveted honor for the dentist, but it would be even finer if he were to perform in a church service for he loves to hear and play hymns.

In fact, Doctor Motley has even considered taking a college music course to broaden his knowledge of the subject.

All of the dentist's outside office hours are not confined to indoor interests and activities. Born in Pittsfield, Illinois, he lived on a farm as a boy. He became fascinated by the wonders of the out-of-doors, particularly about the energetic honey bee. He made a study of the bee, read up on it, and learned how he could start a "tasty" hobby with bees.

At 15 he knew how to hive and take honey from the bee. When Doctor Motley went off to dental college, his beekeeping stopped until a few years ago when he moved to Arlington, Virginia, and bought three-quarters of an acre of land. There he noticed that hardy Dutch white clover grew in the area and remembered the good times he had with his beehive hobby as a boy. Doctor Motley now has eight hives in his backyard consisting of over 750,000 honey bees. Last year he canned over three hundred pounds from his brood of eight bee colonies. What do his neighbors say about the swarm that hovers over the neighborhood? What can they say —Doctor Motley keeps them supplied with all the honey they can eat, free of charge.

Other Hobbies

Doctor Motley is also a floriculturist. In his vast backyard are over two hundred azalea plants and fifty rose vines that ramble over an eight-foot trellis, which surrounds his grounds. The high trellis prevents the bees from bothering the neighbors, for they have to hurdle it and stay high in the atmosphere.

Gardener Motley's azalea collection consists of 15 varieties, and he plans on building it up to include all of the types that will survive in the Arlington region.

Roller-skating, music, bees, flowers and plants, are just a part of Doctor Motley's interesting life. Painting is the favorite of the dentist's hobbies. The walls of both his office and his home are covered with original oil paintings. He has even sold some at a profit. He makes the frames for his paintings, of chestnut or white pine wood, and applies gold leaf and gesso finish to them. Some of his frames are hand carved.

If and when Doctor Motley quits dentistry, he still could make a fairly good living as a stenographer, for during college days he was also a capable court reporter, and earned his way through dental school doing stenographic work and odd jobs.

To work a full day at a dental chair would be a task for even most young dentists, but the day is just beginning for Doctor Motley when he closes his office and leaves for home. Dentistry is just a "sideline" now with Doctor Motley, for he has "more important" things to do and care for after office hours.

THE DENTISTS AND NEGROES*

THE KANSAS City District Dental Society has rejected the membership application of six Negro dentists, although its board of censors found each candidate professionally qualified. Asked to comment on this decision, the President of the society said that the vote "speaks for itself." With due respect for the officer in question, that is neither a persuasive nor an enlightening explanation.

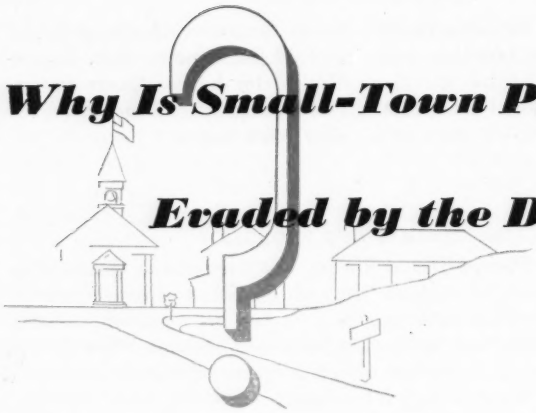
Many dental societies throughout the country admit Negroes. The companion health organization in the Kansas City area, the Jackson County Medical Society, accepts Negro physicians. Why then does the dental society deprive Negro members of an essential profession of opportunity furnished their white colleagues for keeping abreast of new scientific developments and which prevents them from belonging to the state and national organizations?

The vote itself does not answer that question, except by implication. All the vote seems to say is that 56 members of the society believe that properly qualified Negro dentists should be admitted to the appropriate professional organization of the community in justice to themselves and to their patients, while 57 members apparently place their own racial prejudice above all other consideration. We say apparently, because we cannot conclude that many of the dentists in the second group actually expressed their considered judgment.

The Kansas City District Dental Society is not a social club. It is an organization of scientifically-trained persons seeking to promote a humanitarian goal. Prejudice has no place in such an enterprise. Moreover, such a society is a vital part of our community structure. When it acts as it did on those six applications, it damages the total fabric of our race relations, and this affects even the dentists themselves in their capacity as citizens, just as it affects the great body of their patients. We are confident that sooner or later the necessary two-thirds majority will take an enlightened view of both their professional and civic responsibilities. The sooner, however, the better.

*Editorial reprinted from the *Kansas City Star*.

Why Is Small-Town Practice Evaded by the Dentist?



BY D. E. HOLTMAN, D.D.S.

THERE HAS been a great deal of discussion about the lack of medical and dental care in small towns and urban areas. We in the dental and medical professions feel that we have much in common as to our solution of this question.

Over a period of ten years I have practiced dental surgery in a city of 80,000 people, in the United States Army, and in a town of 600. I have been in a city of 11,000 for the last four years and find it most suitable.

It seems the health professions have been blamed unjustly because more men have not located in small towns. There are two sides to this controversy. It is my desire to show that the small town should undergo a transformation in the thinking of its population before more professional families can be expected to join the community.

The people in a small town can be selfish. When they do have a dentist, he is there to help them in an emergency. When Billy or Joan Brown has a toothache, it is nice to know that Doctor Jones is available, and will take care of the troublesome tooth. Then their parents can sleep peacefully through the night. When it becomes necessary to put in a space maintainer or bridge to replace the extracted tooth, Mr. and Mrs. Brown decide that they should consult a specialist in a larger city. They feel that the dentist in a small town may be an inferior practitioner or he would have located in a metropolis.

I had the experience, while in the town of 600, of having restored a girl's mouth to excellent condition as far as restorations were concerned. When all the cavities had been taken care of, I spoke to

The attitude of people in small towns toward the professional man discourages him from settling there.

her father, a successful business man, and advised him to take his daughter to an orthodontist in a metropolitan area and have her teeth straightened. He went to that city a number of times each month on business, so he would not have had to make extra trips. However, he said I was "all wet"; his daughter could eat well and suffered no pain. His attitude was, "Why fool around and spend more money on her teeth?" Since then, I have moved from that town to my present location, and this family has taken my advice. A dentist in a large city informed them that their child's teeth were in a good condition so far as caries was concerned. However, her teeth were not straight and should be corrected by a dental specialist. They consulted an orthodontist, who fitted the girl with braces. Why did not they heed my advice a year sooner? They felt a small-town dentist was not to be trusted. It is that undesirable feeling, found among people of small communities, that any professional man, who practices in their town must be inferior.

The family of a professional man in a small town is under the close scrutiny of the townspeople. Any expressed opinions or undesirable actions on their part reflect against the dentist. He must not express himself too emphatically on civic matters. It might appear that he is taking advantage of his prestige in the small community.

The educational system in many small towns is inferior to that in cities of 7,000 and more. Men of the dental profession realize that certain fundamentals of education should be mastered. Without an adequate education their children will find it difficult to succeed in later years.

To illustrate some of the points I have mentioned I recall the town of 600 where I practiced previously. The educational system there was inadequate, and I openly expressed this opinion. A group of the townspeople, who were interested in educational progress, nominated me for the school board. Immediately a complacent group of people busied themselves making telephone calls. They called all their friends urging them to vote against me. A larger group of people voted in the election than ever before. I learned later that I was defeated because the majority of the populace were of a different religious denomination than I.

It was this narrow-minded attitude that caused me to leave the small town for a larger city. I have since learned that this incident led to an investigation of the school system, and since that time many improvements have been made.

Another hindrance to locating in a small town lies within the medical profession. Many professional societies and organizations do not accept small-town practitioners as equals. You may become a member of these organizations if you meet their requirements, but it is unlikely that you will be elected to an important office. The men with large city addresses add more prestige to their group.

A physician friend of mine is listed in WHO'S IMPORTANT IN MEDICINE. This man has contributed a great deal to medicine. He has served as director of a national medical organization. Later he was elected vice-president of this group. However, when his name was proposed for the presidency, the nominating committee ruled against his election because he resided in a small town. It was argued that this fact did not bring sufficient prestige to the organization.

Obviously small towns have advantages as well as disadvantages. It is easier for one to form close and lasting friendships in a small town. The pace of living is not too fast so that one can enjoy a little more leisure that would be spent in commuting if he resided in a large city. Perhaps jealousies and selfishness are more pronounced in smaller communities where one knows his neighbor intimately, but human beings are the same wherever one lives. I presume the final solution is a personal one that is dependent upon a person's ability to overlook these vexations which become paramount in a small community.

1817 *Washington Street*
Two Rivers, Wisconsin

DEATH AND DISTINCTION

IT SEEMS contrary to obvious facts not to conclude that the medical profession has maintained its financial and social status by working twice as fast with the aid of mechanical devices. Though to the conservative physician the attribution of such organic disease, as is involved in the atheroma-arteriosclerosis-hypertension syndrome and its lethal complications, to anything so nebulous as the psychosomatic concept of mental exhaustion and anxiety is obnoxious, it cannot be denied that evidence in favor of this view is accumulating steadily. As has been remarked by R.H. Ward, "We do not live in an age of reason or even in an age of romance, but in the age of anxiety," and it is upon those who live by their intellect, if not by their intelligence, that the impact of such an age must fall.—ORDE POYNTON, M.D.—*Journal of the American Medical Association*, December 12, 1953.



DEAR ORAL HYGIENE

Fluoridation

If I were a small-town professional man who thought that a little publicity could do no harm, I think I would write an article for a widely distributed and highly esteemed publication and in it I would take a stand flatly opposing something that almost one hundred per cent of those best qualified to judge its merits, strongly supported.

After I took this stand, I would then and only then, look about for reasons, no matter how frivolous, ill-founded and illogical, to buttress my position. Of course, the well-meaning but guileless members of the craft that developed this theory by painstaking observation, self-sacrificing experiments and conclusions, which can only do a disservice to the guild, will rush into print to point out his fallacies. Thus, we unwittingly add fuel to his bonfire. Shortly, there is the chance that we may overlook the original thesis and talk only of the man.

Let us now consider Doctor Forman's case against fluoridation.[1] His first point is that inorganic fluorides inhibit certain enzymes, that this inhibition leads to certain adverse conditions. There are areas where fluorides are in the water naturally and where endemic fluorosis is prevalent. Has he or any of his coworkers observed these effects in these areas? Do they occur where the fluorides occur in 1 pp million or less? If not, it is like saying that drinking water is dangerous because many have drowned in water. He next refers to organic fluorides that also come under the heading of drowning. Nowhere have I ever seen reference made to the use of organic fluorides.

He next refers to overdosage in warm climates because of excess use of water. Nowhere in the Constitution have I seen any injunction against varying the percentage of fluorides as conditions warrant. This would also apply to the variations indicated by the favorite diet of the area and the foods available.

His references to varying the amount of fluoride to allow for variations in caries susceptibility is typical of this writer. How can you determine this susceptibility until it is too late for internal fluoride? He ends his second page with an unintelligible appeal to all religious groups on a purely scientific matter. He then starts to worry about diabetics and expectant mothers, although the latter, it would seem, should be the first to take the NaF, and starts to theorize about the possible effects on them. At this stage it is not necessary to rely entirely on theory. We have been fluoridating more than one hundred areas and statistics are now available. I know of no adverse ones. If he does, let him produce and substantiate them, and not prattle of topical fluorides, which my group has not found effective, or of individual dosages, which are impractical. The entire problem of caries, particularly here in America, is a serious one and for all I know an increasing one.—EDGAR P. WARNER, D.D.S., 58-13 *Woodside Avenue, Woodside, New York.*

[1] Forman, Jonathan: Fluorine On Tap: The Case Against It **44**:48 (January) 1954.

Fluorine Is Not Essential For Human Life

When a person is forced to imbibe a dose of an element that has never been

proved to be essential to animal life, that has highly toxic properties, and that is a declared health measure for the partial prevention of dental caries, it seems pointless to deny that artificial fluoridation of drinking water is mass medication.

Fluoridation of water treats human beings; they are impregnated with the fluoride ion. Chlorine, on the other hand, treats water to make it safe for human consumption.

Fluorine is concentrated when the water is boiled; chlorine is dissipated.

For those who believe that fluoridation is no longer experimental, and that it is good and presents no hazards, there is a simple method that will cost approximately seventy-five cents for a three-year supply of the advocated dosage per child. It will not be necessary to have an added community tax burden for the rest of your lives.

If you were to be refused the right to treat water with chlorine for waterborn disease, your health would be jeopardized. But to insist that others take a drug for a noncontagious disease, when you are allowed to take it as you wish, is tyranny. Why should you demand that those who consider fluoridated water hazardous be forced to take it? There is no contagion involved, and no reason for undue haste.

Until the experiments are completed in the pilot cities and unless the safety factors have been firmly established, a public health measure will once again run the risk of becoming a public health hazard.—A. ALLEN LONDON, D.D.S., *Boonton, New Jersey.*

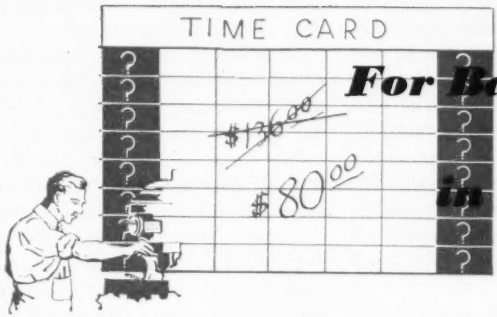
WHAT PEOPLE EXPECT FROM A DENTIFRICE

PEOPLE USE a dentifrice to clean their teeth. Most of them do not expect it to prevent dental disease. Among 8,320 persons answering the questionnaire of the Bureau of Economic Research and Statistics of the American Dental Association, 47.1 per cent expressed themselves as expecting a dentifrice to be a tooth cleaner, to taste pleasant, to feel refreshing, to look attractive. Only 4.7 per cent expected a dentifrice to prevent or control dental disease. The recommendations of dentists (5.5 per cent) were more effective in influencing a person's selection of a dentifrice than were any of the forms of advertising (1.1 per cent).—*Journal of the American Dental Association,* November, 1953.

DENTAL CHECKUP MAY REVEAL EARLY SIGNS OF A DISEASE

THE ORAL cavity is by its position the first part of the digestive tract, and is also in close relation with the respiratory system. Hereditary and constitutional factors affect its development and reactivity. Blood vessels, lymphatics, and nerves ensure rapid and quick intercommunication between it and the rest of the body. It is also affected by nutrition, metabolism, and endocrine balance or imbalance. In many ways it reflects like a mirror the state of systemic health, so that the dentist, in his periodic check-up of the patient, has an opportunity to discover the earliest signs of a disease, while it is still curable or controllable.—*Journal of the Egyptian Medical Association.*

Watch Out For Bad Debts in 1954



BY HAROLD J. ASHE

A patient who was a first-rate credit risk in the past may be a bad risk this year.

IF EXTREME care is not taken, dentists are likely to accumulate more bad debts in 1954 than in any year since 1940. More and more accounts on a dentist's ledger will bear watching; new accounts may contain a higher element of risk than in the past.

Several circumstances will contribute to this situation. Unless all predictions are wrong, competition for the consumer's dollar is to be sharpened. This will come coincident with a reduction, however slight, in the number of such dollars. While business is expected to decline only moderately, individual income (distribution of purchasing power) is due for a painful reshuffle in the case of many consumers. This is a process to which dentists should be alert. Some consumers, who have been considered first-rate credit risks in the past, now are going to find it difficult to meet their commitments. Many marginal accounts will fall into the bad risk class. This is going to be no less painful for debtors than creditors.

Dentists who continue to think in terms of past collections and bad debt losses may have trouble. Ordinarily a record for paying off dental bills may be a sound guide for granting new credit, but this test will need to be qualified in 1954. For eight years the goose has hung high for most consumers; not a few of these are going to be put through the wringer in 1954

even though the overall adjustment, reduced to a statistic, may be moderate.

Even if individual incomes suffer a reduction overall of only five per cent or thereabouts as many predict, adjustment will not be distributed evenly among all income groups or among all categories of people. To so assume is to oversimplify the interplay of economic forces in 1954. To reduce the problem to a matter of simple arithmetic is to miss the implication of what is expected to take place.

People with fixed incomes may benefit slightly because of dollar stabilization and income tax reductions. Salaried persons may gain slightly. On the other hand, that large segment of the population made up of wage earners may be hit much harder. Wage earners' pay checks are based on hourly rates. In many instances, these hourly rates may even rise at the same time that take-home earnings drop drastically. This will be due to the fact that more and more employers will cut back the work week to 40 hours or less.

Overtime rapidly is becoming a thing of the past. Yet, and this is important to dentists, it was largely overtime income at time and one-half, double time and even triple time, which accounted for payment for professional services in past years. Even credit accounts have been budgeted in relatively high take-home pay checks of past years.

Thus, people who have made purchases on time, and have been given professional services on credit, are already having difficulties meeting payments with reduction of the work week.

Some wage earners, rather than recognizing the stark realities of their dilemma, have further extended their credit to stave off disaster. They cannot quickly adjust themselves to a drastic cut in take-home pay. As an alternative they are going even more deeply in debt. Every purchase, every professional service secured on credit serves to supplement cash purchasing power.

Moreover, by using credit to the limit, such persons temporarily are able to divert limited earnings to pay other, more pressing, obligations. By getting dental services on credit, which otherwise they would pay cash for, a patient is able to divert this cash to pacify a finance company carrying a conditional sales contract.

Dentists who grant credit to such patients are in effect helping them to pay off commercial debts. Therefore, it is imperative that dentists take a new look at the facts surrounding credit applicants. The fact that a patient contracted a large bill in 1951 and liquidated it on time is no indication he can meet a large dental bill contracted in 1954.

For example, consider the case of a skilled factory worker, who for years has held a job providing

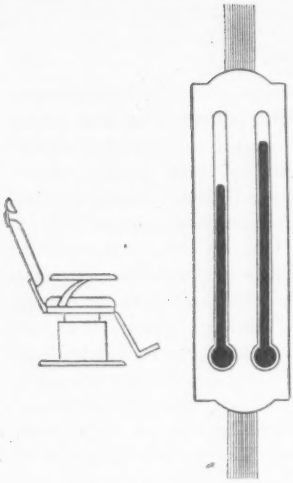
Saturday and Sunday overtime. His hourly rate is $2. For 40 hours he gets $80. Saturday employment at time and one-half fattens his pay envelope by another $24, and Sunday employment brings an extra $32. From a weekly pay check of $136, before deductions, he is cut back to $80. This drop in income drastically alters his manner of living. It even more sharply reduces his income, after basic necessities of shelter, food and clothing are provided for. In that $80 check, less withholdings, there is not much purchasing power or ability to make monthly time payments on bills contracted on the assumption of far higher earnings. This patient who once could handle several substantial monthly payments without feeling them suddenly becomes preoccupied with an unexpected dental bill of $15 or $20.

Dentists, in 1954, need to re-evaluate credit accounts in terms of 1954 ability to pay. Past performance may prove misleading and lay the basis for an excessive number of uncollectible accounts. New credit reports may be good insurance where there is doubt.

846 *West Palmer Street*
Compton, California

HOW TO PREVENT MALPRACTICE CLAIMS

1. Handle cases only within your professional qualifications; call in consultants whenever necessary.
2. Do not be overoptimistic in prognosis.
3. Always obtain adequate consent.
4. Always keep adequate records for your own as well as your patient's protection.
5. Always have roentgenograms taken of bone and joint injuries. Use laboratory tests, even though simple, when indicated.
6. Make frequent enough calls and give sufficiently precise instructions so that there can be no misunderstanding. Be sure you write your prescriptions legibly.
7. Be sure that your patients are covered by medical (or dental) attention in the event of your absence.
8. Know what to do when the patient does not follow instructions or discontinues treatment.
9. Do not gossip about your cases.
10. Do not criticize your professional colleagues.—CIVIL MALPRACTICE —BASIC PRINCIPLES, W. W. JETTER, *The Medical Clinics of North America, Philadelphia.*



You Can Control the Weather*

TIME WAS when weather was a matter we all had to put up with. Uncontrolled by man, capricious and variable, weather along with taxes was the inevitable and the uncontrollable. Today, man is the master of weather.

For example, scientists have built laboratories in which any kind of weather can actually be made, temperatures as hot as the Sahara, as cold as Siberia, and even fog as thick as London's.

But scientists do not have a monopoly on weather-making. You can make your own weather, too. You can do it with a room air-conditioner. The mighty marvel of the modern electric age, air-conditioning is expected to undergo a period of growth in the next few years no less sensational than that of television in recent years. There are some who expect that the day is not far off when air-conditioning will be considered as much a necessity of modern living as is the shower in the bathroom, itself once considered a luxury.

For professional men particularly, the promise of air-conditioning is great, the benefits of air-conditioning many.

The enthusiasm of dentists for air-conditioning runs high. What's more, the saturation runs high. According to figures released by the National Association of Manufacturers, 10 per cent of all air-conditioners are sold to dentists, physicians, and professional men. This is a national figure and reflects the greater saturation in the South. But the trend toward air-conditioning is on the move in other parts of the country too. One reason for this is the realization that air-conditioning equipment does more

*Reprinted from *Massachusetts Dental Society Journal*, July, 1953.

than just cool. An air-conditioner has year-round use because it filters dust, dirt and pollen from the air, thus helping to keep offices and equipment more sterile; it shuts out noise from outdoors, and many air conditioners provide supplementary heating as well as cooling.

Recognized as an important business investment, air-conditioning permits professional men to serve their clientele in greater comfort and with greater convenience. Many dentists report that in warm weather particularly, patients who would otherwise be somewhat nervous, apprehensive, and uncomfortable feel much more at ease. In fact, dentists who previously were in the habit of closing their offices for many weeks during the summer now continue to see patients.

Of the many varieties of air-conditioning equipment now available, the standard features in most are the ease of installation, attractive design, simple controls, quiet performance, and economical operation.

An implicit benefit is that air-conditioning is a symbol of progressiveness that adds prestige and good will. As you know, people do go out of their way to patronize air-conditioned businesses.

Here are some interesting facts on heat and its effect on the human body. The body is an automatic heat pump that works 24 hours every day of our lives in winter and summer. It gives off as much heat as two 100-Watt light bulbs. In cold weather, this body heat presents no problem because it is dissipated into the colder air. In fact, body heat escapes so quickly in cold weather we have to wear more clothing to retain it. The colder the weather the more protection we need to feel comfortable. In extremely cold weather it is necessary for us to protect our health and safeguard our comfort. It is equally important to do so when the weather is extremely warm.

In warm weather we feel uncomfortable because it is more difficult to get rid of the heat which the body continues to generate. Physical activity adds to our discomfort because it increases the body heat. Exposure to high temperatures not only makes us uncomfortable, but can often result in ill-effects.

The heart works harder and faster to pump more blood to the surface of the skin. This increased activity of the heart causes the pulse rate to increase as much as 40 per cent and causes a heart strain which can be serious for people in all age brackets, especially for people over forty. The fact is, in a 95° temperature, the simple act of walking can cause as much strain on the heart as heavy labor which is performed under comfortable temperature conditions.

Digestive organs are cheated of their normal blood supply because more blood is being pumped to the surface of the skin. The result—

poor digestion, headache, lower body resistance, digestive upsets, loss of weight and even serious illness.

Mental laziness and the inability to concentrate, which are common at high temperatures, cause the heart to pump less blood to the brain. A recent study showed bank clerks committed 50 per cent more errors when the temperature was in the nineties than they did when the temperature was at 68°.

Excessive perspiration causes the loss of mineral salts. This loss of salts, particularly iodine and chloride, frequently results in cramp and in fatigue.

To be comfortable in warm weather, the heat generated by our body every minute of the day must be removed. The best way to do this is to disperse the heat into the surrounding air, but to do this the air must be cooler than the human body; it must be dry enough to absorb moisture; it must be in motion to speed up the process of evaporation.

Air-conditioning equipment does just this. It cools the air, removes the moisture, and circulates the air. Consider all the benefits of air-conditioning. Consider, too, that it is a business investment and you understand why the air-conditioning boom is growing day by day.

KELLOGG FOUNDATION HELPS PEOPLE TO HELP THEMSELVES

W. K. KELLOGG endowed the foundation that bears his name with its principal assets, which at present values are worth over eighty-five million dollars.

Although Mr. Kellogg held aloof from the day-to-day work of the Foundation, his general conception of what a philanthropic enterprise should be and how one ought to function unquestionably made itself felt. As much as anybody, he was responsible for the circumstance that although the formative years of the Foundation coincided with the great depression of the 'thirties, when the need for charity was acute, it has always sought to achieve its aims primarily through educational means, rather than through direct-service functions. As he once wrote to the Board of Trustees, after the Foundation had been operating for a number of years: "I am glad that the educational approach has been emphasized. Relief, raiment and shelter are necessary for destitute children, but the greatest good for the greatest number can come only through the education of the child, the parent, the teacher, the family physician, the dentist, and the community in general."—EMORY W. MORRIS, D.D.S., *President and General Director, W. K. Kellogg Foundation, Battle Creek, Michigan.*

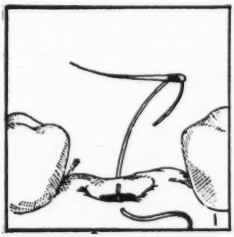
TECHNIQUE of the Month

Originated by W. EARLE CRAIG, D.D.S.

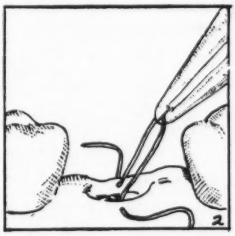
Controlling Hemorrhage from a Socket

BY HERMAN MEYERS, D.D.S., AND LOUIS L. SCHWARTZ, D.D.S.

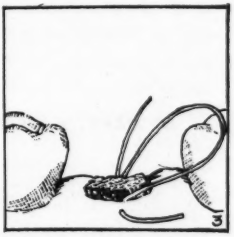
Drawings by Dorothy Sterling



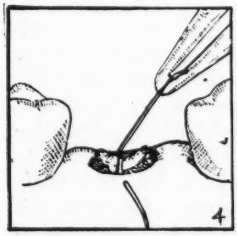
Clean the mouth thoroughly. Run a suture through the buccal and lingual muco-periosteum.



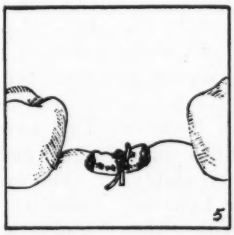
With a hemostat, grasp the suture at a point over the socket and pull to create a large, free loop.



With suction or instruments, remove the blood and partly-formed clot from the socket. Fill the socket with a strip of Hemopak.



Pull ends of the suture to eliminate the free loop.



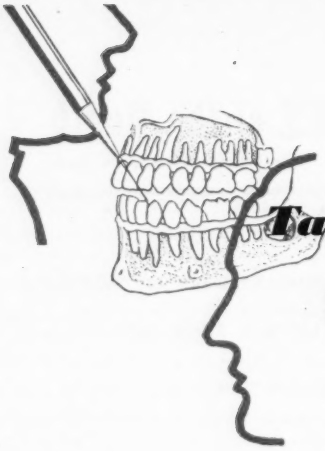
Tie ends of suture.

Note to Contributors

We invite dentists to submit material for this page. $10.00 will be paid for each technique used. It is not necessary to make finished drawings—or even sketches—if you explain the procedure clearly, in detail, in your letter. Submit material to:

Technique of the Month,
Oral Hygiene,
1005 Liberty Avenue,
Pittsburgh, Pennsylvania

Editor's Note: A department similar to this one, "Clinical and Laboratory Suggestions," appears each month in Dental Digest.



Take Time to Tell Your Patient

BY HARRY C. PEAKE, D.D.S.

AFTER hospitalizing patients and operating in hospitals for many years, I have recently had a new experience. I was a surgical patient in a hospital myself. The side of the fence the viewer is on makes a vast difference in the ball game.

When I was taken to the operating room the anesthetist asked me if I had a preference in anesthetics. Possibly he would not have done this with a nonprofessional patient, but in my case the approach was right. Naturally I left the decision to him, but he had instilled confidence in me concerning his ability. Considering the fact that I did not know him even by reputation, this confidence was of value to both patient and anesthetist.

In the case of a layman, he might have said he was going to employ cyclopropane (or whatever anesthetic he had chosen) for such and such a reason. The result would be the same. Confidence would be created, and the patient would not feel he was being taken into the unknown by a man who chose to surround himself with an aura of mysticism.

My surgeon was a competent man—one in whom I had complete confidence, but like most other top-ranking men, was rushed off his feet. Since he had many patients in the same hospital, he had developed a species of code when giving instructions to the nurses. That saves a lot of time, but what of the patient?

The average patient is a fairly intelligent person. He does not possess a scientific knowledge of anatomy or the functions of the various organs, but is interested none the less. Tell him what is going on. Fear of the unknown is the worst fear of all.

Most dentists consider the ex-

A patient will be more relaxed and cooperative if an operation is explained to him beforehand.

traction of a tooth as commonplace as clipping fingernails, but a patient does not share this feeling. Even the big man with the build of a wrestler may quake in his shoes, however much he tries to hide it. An extraction is a dreaded operation. Do not underestimate it, and do not surround it with mysticism.

I always find that a patient for conduction anesthesia is a much better subject if the operation is explained first. To one who has never experienced a mandibular block, the sensation of a hypodermic needle probing in that area is most disconcerting. He sits waiting for the needle to strike a vertebra or some vital structure! However, if the local anatomy is explained, and the patient is assured that you not only know exactly where to place the solution, but the risk involved is *nil*, the fear of the unknown will be dispelled.

Startling Patients

This does not mean the whole procedure should be explained in detail, or that the hypodermic syringe should be waved in his face. Far from it. A needle that is actually one and seven-eights inches in length may appear like a bayonet to a highly nervous person. On the other hand, never sneak up on a patient with a hidden instrument of any kind, and pop it out at him like a magician bringing a rabbit from a hat. That can scare the hardiest soul and create tension—the last thing desired in a dental operation.

This applies to children as well as adults. Your office itself is a place of mystery to a child on his first visit. Put him at his ease as far as possible by explaining. Children are intelligent too, prone as we are at times to overlook the fact. The average child will submit to what is explained to him, but will never forgive being frightened. I have had adult patients tell me that they have never been in a dental office since they were small children as a result of a scare or having treatment forced on them. I have also had a fragile little five-year-old-girl submit without a whimper to a mandibular block and the extraction of a lower first molar after the procedure had been explained to her.

The same applies to restorative treatments. Sometimes an enamel wall breaks down with a resounding crash. At least, the patient *thinks* it is a resounding crash. Actually, this occurrence may simplify the preparation. It may even have been done intentionally, but to the patient a major catastrophe has taken place in his mouth. At least half the tooth must have

broken off—it will have to be extracted—maybe the rest will break off and the root will have to be "dug" out—or a dry socket will result. So his imagination goes racing on if his mind is not put to rest at once.

Dentistry is a profession where a "poker face" is often an asset. A dentist should never reveal his momentary emotions. Should a root fracture during an extraction it would be unwise to allow a "what do I do next" look to flicker across his face. You know what to do and the next minute will be busy doing it, but the patient does not understand this. He will see that look, however fleeting, and his imagination will run rampant. Keep your facial muscles under control and clarify the situation. Should the case prove to be beyond your scope, *explain* the reason and make an appointment for him with a specialist who can handle it.

Momentary looks of annoyance or chagrin over some trifling mishap during an operation are a mistake. The patient may magnify the cause a hundredfold unless he understands what has happened.

Only a charlatan will knowingly try to fool the public. The witch doctors relied on mysticism to retain a hold over their followers. Let us, as dentists, rely on our skill and the fact that we have discarded mystery and have adopted truth and fair dealing to hold our patients.

Parkhill
Ontario, Canada

GLAND ACTIVITY DETERMINES RATE OF AGING

THE IDEA of comparing the human body with an automobile engine, which does wear out, appears to me to be wholly misleading. The cells of living things are being constantly replaced. The turnover is such that it is said we have a new body every seven years. There is no evidence that the rate at which we grow old varies directly with the rate at which we live. Indeed, the rate of aging is determined by changes in the activity and interrelation of our glands of internal secretion. The only way I know of favorably influencing this endocrine pattern is to function as fully and actively as we know how. It is my belief that throughout the realm of living things, nature tends to eliminate those that have relinquished their functional usefulness. In man, nature does it by changing the pattern of activity of the glands, perhaps the thyroid in particular, so that arteriosclerosis ensues and with it the body withers, sometimes slowly, sometimes quickly. The process of degeneration and death as seen in the smallest unit of the body, the cell, starts with the appearance of fat globules. What is true of the cell unit is, I believe, equally true of the body as a whole which is, after all, merely equal to the sum of its parts.—THEODORE G. KLUMPP, M.D.



Dentists in the NEWS

New Orleans (Louisiana) Times-Picayune: The first woman dental officer in the United States Air Force is First Lieutenant Raya Rachlin. She received her commission last fall and has been assigned to Kessler Air Force Base at Biloxi, Mississippi, for her initial permanent duty tour. Doctor Rachlin was educated in Germany and held positions as dental techician in military hospitals in Shanghai, China, and the United States.

Lancaster (Pennsylvania) Intelligencer Journal: Letters from all over the world have been sent to the Lancaster Cleft Palate Clinic since an article entitled NEW FACES FOR OLD appeared in the English and Spanish editions of ORAL HYGIENE several years ago. Not only mothers and relatives of sufferers and victims have written, but also physicians and dentists who want to know more about cleft palate therapy and how they can help their patients. Doctor Herbert K. Cooper, founder and director of the clinic, says he has had letters from almost every state and most of the countries in South America, and as far away as India and Western Australia. Patients have come to the clinic from most of the states and also from Holland, Puerto Rico, Mexico, Brazil, Colombia, and Canada.

Seattle (Washington) Times: For twenty years Doctor Peter Schranz practiced dentistry in a conventional type of office in a Seattle building. Ten years ago, he closed his office and went to sea, with a 42-foot sailing boat as his office. Since then, Doctor Schranz has traveled to Alaska, Hawaii, and other far-off places to serve the dental needs of patients. Many of his patients live in isolated spots and could not reach another dentist unless they traveled for days by boat. His wife helps out as his dental assistant.

New York (New York) Times: Apparatus that protects a building by spreading a circular water curtain between it and a fire burning in an adjacent structure has been patented by a Norfolk, Virginia, dentist, Doctor Jack C. Kanter, 315 Wainwright Building. The "water shield" can be connected to a hose, clamped to the roof or outer wall of a building and left unattended by firemen. Its nozzle rotates under the water pressure and sends a thick sheet of spray into the air and over the wall.

New Orleans (Louisiana) States: Doctor Mabel Fontaine Wood, Maison Blanche Building, director of dental activities for parish schools in New Orleans, has been appointed a fellow of the American Public Health Association. She received the honor "in recognition of professional standing in the field of public health."

American Magazine: Doctor H. L. Whytock of Salt Lake City, Utah, thinks 99 is not too old an age to roller-skate or ice skate, and he does both. He began skating when he was a boy of five in Scotland, has taken lessons from 42 instructors and given lessons to several times that many students. The retired dentist thinks the sport helps a person develop a system of balance and coordination exercising muscles that otherwise would not be used. Doctor Why-

tock is also an expert horseman and owns two Arabian mounts.

New York (New York) Daily News: A dentist in Chicago, Illinois, was bitten when he came to the rescue of a mother and her child who were being attacked by a dog. A rabid dog bit the woman and her son outside the dental office of Doctor Robert J. Carroll, 1376 West 79th Street, who grabbed the dog and was bitten when he threw the animal into his office and locked the door. The dog tore office furnishings and equipment to shreds before police shot it. Several organizations in the dentist's neighborhood presented him with awards for his feat. The Morgan Park Woman's Club and the Mt. Greenwood Methodist Church congregation gave him checks, which he turned over to the parents of the child who was bitten. The American Legion post and the Lions Club in his community honored Doctor Carroll with citations, and an alderman, acting in behalf of local citizens, presented him with a bronze plaque for community service.

Houston (Texas) Chronicle: One of the newest protective devices on the market for football players is a mouthpiece designed by a Weslaco, Texas, dentist, Doctor Milton H. Chandler. He spent four years perfecting the mouthpiece, which is made of rubber and fits over the upper teeth. Coaches whose teams have used Doctor Chandler's invention say it is an excellent protection for players' teeth and jawbones.

Philadelphia (Pennsylvaina) Inquirer: Twenty dentists will treat handicapped children from the Widener Memorial School in Philadelphia, in a series of weekly visits to the Einstein Medical Center dental clinic. Doctor Abram Cohen, 269 South 19th Street, chief of the dental division of the Board of Education in Philadelphia, and Doctor Gustav C. Tassman, 714 Medical Arts Building, head of the hospital dental clinic, arranged the visits.

Albany (New York) Times Union: Doctor Louis B. Amyot, 9 North Church Street, Schenectady, New York, has what he calls "Arctic fever." The dentist has made seven trips into the Far North and crossed the Arctic Circle four times. Last summer he went on a two-month voyage as assistant to the medical officer of the *d'Iberville*, a Canadian icebreaker. Doctor Amyot joined the Grenfell medical mission in 1936 and served in Newfoundland and Labrador as a dental officer. He tried to enlist in World War II, but was turned down, and so joined the Eastern Arctic Patrol of the Canadian Merchant Navy. On later trips he has been engaged by Canada's Indian Health Service and made a special study of the teeth of Eskimos.

St. Paul (Minnesota) Pioneer Press: A German dentist, Doctor Oscar Scheffler, and his family were reunited in St. Paul recently and after a life story filled with heartbreak and adventure hope to build a better life in the United States. In 1945 Doctor Scheffler was a prisoner of war in France and his wife was living with her parents in Saxony when the United States Army announced that the Russians were to take over occupation. Mrs. Scheffler left her home when the Russians moved in, but her parents remained to operate their candy factory. A year later Doctor Scheffler began his study of dentistry at the University of Heidelberg, and after graduation in 1950 he served in the United States Army dental clinic. By the summer of 1951 he was ready to leave Germany, and the Schefflers planned a last visit with Mrs. Scheffler's family. But her mother and father never reached the meeting place, for they were imprisoned and their home and business confiscated.

The dentist and his wife and their young daughter went to Canada where

he worked for the Department of Health and Welfare in the Indian service. In 1952, Mrs. Scheffler's parents were released and her mother joined them in Winnipeg. Her father chose to stay in Germany. Last November the dentist and his wife moved to St. Paul where he is employed as a dental laboratory technician while waiting to take the State Dental Board examinations through which he hopes to qualify for dental practice in this country.

San Diego (California) Evening Tribune: A National City, California, dentist, Doctor Cozier W. Gilman, 219 East Eighth Street, was named "Outstanding Young Man of 1953" by the San Diego Junior Chamber of Commerce. He received a certificate and plaque and was commended for "being instrumental in passing a physician and dentist draft law that was honest." The 32-year-old dentist organized the National Dental Veteran's Association, and is active in the San Diego Childrens Health Association and the National City Cancer Society.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

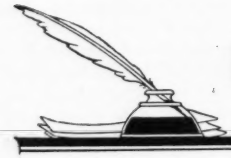
Miss Lillian Eagan, 4 South Allen Street, Albany, New York
Mrs. L. Vellat, 508 West 62nd Street, Seattle Washington
Lisbon Schmeiske, D.D.S., 198 Court Street, Binghamton, New York
M. H. Chandler, D.D.S., P.O. Box 565, Weslaco, Texas
R. B. Moore, D.D.S., Box 237, Allerton, Iowa
Theodore Katz, D.D.S., 2802 Grand Concourse, New York, New York
J. M. Crown, 40-12 59th Street, Woodside, New York
L. Fricker, Quarryville, Pennsylvania
L. A. Cloud, 1223 St. Mary Street, New Orleans, Louisiana
Adeline E. Cohen, Uptown Station, St. Paul, Minnesota
Joe G. Cook, 415 Second Street, Gulfport, Mississippi
Jack E. Weaver, 3328 Cedar Street, San Diego, California
Colonel William Perry, Rittenhouse Claridge, Philadephia, Pennsylvania

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

SECURITY AND FREEDOM GO TOGETHER

THE INCREASING demand by the American people for more Social Security benefits was not the result of a decline in courage, stamina or moral fiber, and should not be taken to indicate that Americans are becoming "soft." Increased interest in Social Security is based on interrelated economic, social and psychologic changes in the country over the last fifty years.—*From Columbia University's American Assembly on Economic Security.*



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

RESEARCH NEEDS MORE THAN MONEY

A NATION that gives away billions of dollars to help countries throughout the world would be expected to have more regard for the health and well-being of its own people. Many of our citizens cannot afford to pay for health care. Millions of our people would be benefited by the results of research on the diseases that distress and kill them. Research needs money. With the present excessive taxes this money cannot be expected to come from wealthy persons. The days of large private philanthropy are over. The tax laws have seen to that.

If research on disease is to be done and large sums of money are not available from private sources, the only place to expect support is from the government. This is distasteful to many of us. We should prefer to have private enterprise carry on this work rather than have it dropped into the lap of a government agency. Realism requires us to face the fact that, if the job is to be done, the government must help. Tax funds may be used directly to support work in such organizations as the United States Public Health Service, or tax funds may be used as grants-in-aid to universities and private research organizations. Both methods are being used at present.

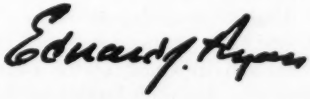
In the past a small part of the research dollar has gone to dental studies. Asgis[1] shows that, for 110 million dollars spent in one year for medical research, 1 million was spent for dental studies. Of this amount of 1 million dollars $733,000 was the total spent by 40 dental schools in the United States. This means that each dental school in the United States spends on an average less than $20,000 a year for research. In the same period while 3/4 of a million dollars was spent by the dental schools 24 million was spent by the medical schools in research.

[1]Asgis, A. J.: Scope of Research in Dentistry. N. Y. State Dent. Jour. **20**:6-16 (January) 1954.

There are people whose wishful thinking is more exuberant than the hard facts at hand, who believe that sodium fluoride in the water supplies will reduce the caries experience to a place where this disease is no longer a major health problem. Even if the caries rate were reduced 40 per cent by this procedure, which is doubtful to many observers, the incidence of this disease is still high. This means that other avenues of research must be found to control the 60 per cent incidence of the disease. So far as periodontal disease is concerned, nothing specific has been suggested that appears to be a fundamental approach to this condition. If anyone has proposed a public health approach to periodontal disease the suggestion has not found the way into print, and the treatment methods for periodontal disease are in general less effective and logical than those for caries.

The opportunities for research in dentistry are limitless. The relationships between biologic and environmental forces and malocclusion have scarcely been explored. The vast subject of biochemistry and the relation between oral and systemic disease is a challenge to the imagination of anyone interested in research. The effect of the modern, over-refined, devitalized, processed, frozen and chemically treated foods on the well-being of mankind is a subject in which honest research will be required to battle against powerful commercial interests. The danger here is that the searcher for truth will find his way blocked as soon as he makes a discovery that endangers a profit-making venture. A good many of the men in government high places and on the boards of trustees of universities have their economic roots deep in fields that they prefer to have remain undisturbed.

Research is more than a matter of money. It needs that. It also requires a free atmosphere in which to work: free from pressure groups and vested interests. Such a rare atmosphere is hard to find.



A Dentist's Folk Tales Bring Fame and Gain

BY CHARLES H. WATERBURY

USING HIS spare time between appointments, Doctor Moritz A. Jagendorf has written a vast number of folk stories of America, which have brought him fame and gain. With a published book list now exceeding two dozen volumes, royalties are accumulating at such a pleasing rate that the dentist-author, after nearly forty years of practice, is gradually relinquishing patients to an associate.

Doctor Jagendorf's flair for telling a story in a form easily read, or re-told, has brought him recognition in the literary world. He is President of the New York State Folk Lore Society, Vice-President of the International Folk Lore Congress, and Director of the National American Folk Lore Society.

Under the sponsorship of UNESCO, the educational and cultural activities unit of the United Nations, Doctor Jagendorf has lectured in Turkey and is scheduled to lecture in Yugoslavia and other countries while on a world tour.

From what started as a hobby, Doctor Jagendorf has developed a major activity, which gives him great satisfaction for the joy and laughter it brings to others, as well as an opportunity to ease away from the strenuous demands of constant dental operating. Behind the dental chair he made notes of stories told to relax patients, which produced laughs.

Culled from a reservoir of word-of-mouth accounts of the early life of the country, Doctor Jagendorf has written in vivid action style hundreds of stories from the native life of every part of the country.

Beginning with New England, under the crisp title NEW ENGLAND BEAN POT, followed by UP STATE DOWN STATE—tales of the Middle States, stories are being gathered for the remainder of the country and prepared for publication, each section requiring a separate volume.

Doctor Jagendorf, who came to

New Yorker has written over two dozen volumes of folk stories about every part of this country.

this country from Austria as a boy, points out that while much of the European folk lore is based upon the lives of giants, witches and other creatures of fancy, the essence of American folk lore is in the native economic life. One character represents lumbering, another farming, another the oil industry and so on through varied phases of the economy.

"Folk lore," says Doctor Jagendorf, "represents the dreams of the people—not of life, but the way they would like life to be."

Sherwood Forest

In addition to his travels about the United States, Doctor Jagendorf has visited Sherwood Forest in England. There he dug into the native lore and has woven it into a most entertaining book under the title MERRY MEN OF GOTHAM. These folk tales show how life can be protected by use of wits instead of armor. The apparently foolish are proved to be wise enough to outsmart those who pose as wisely superior.

While thoroughly enjoying writing to make people laugh, Doctor Jagendorf cannot absent himself from his dental practice without getting an urge to put his fingers to work again. Three months, perhaps, and then restlessness to get behind the dental chair again overtakes him.

All of Doctor Jagendorf's stories have been published by The Vanguard Press. His books contain many pen sketches to enliven the pages.

Of his work, Colonel Shoemaker, President of the Pennsylvania Folk Lore Society, speaking of UP STATE DOWN STATE says: "Our folk lore has come to its full ripeness of understanding and can be collected freely. Doctor Jagendorf has shown in this book how it can be done at its best."

Not all of Doctor Jagendorf's literary work has been devoted to folk lore. He has written and published a number of plays for children to be used in clubs, camps, and schools. Plays have been adapted for production by amateurs with the use of limited stage properties. These plays and tales are found on the shelves of many public libraries where they are in almost constant circulation for the help they give to teachers and youth leaders. For a time Doctor Jagendorf directed a children's theatre in New York and was a member of the Washington Square Players.

While in the Army during World War I, Doctor Jagendorf used every leave hour in writing or digging into local folklore.

This dentist-author has shown how much can be done with the

use of idle time to give joy to others and freedom for oneself in the way of economic independence.

His activity is an example of preparation during productive years for that time in life when leisure is much to be desired to replace the stress of a full dental chair every hour of every day.

5D *Lakeside Apartments*
Melrose Park
Philadelphia, Pennsylvania

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ CXVI

(See page 619 for questions)

1. Because of the surrounding infections associated with the gingivae. the continued strain and stress of mastication and the more active growth and development. (Sarnat, B. G.; and Schour, Isaac: Oral and Facial Cancer, Chicago, The Year Book Publishers, 1950, page 159)
2. (b) increase—from more than 7500 per cubic millimeter. (Blair, V. P.; and Ivy, R. H.: Essentials of Oral Surgery, ed. 4, St. Louis, C. V. Mosby Company, 1951, page 68)
3. In mouths affected by periodontal disease, teeth exposed to normal occlusal forces may be traumatized—such a condition is termed secondary occlusal trauma. (Orban, B. J.: Biologic Principles in Periodontosis, D. Digest **57**:251 [June] 1951)
4. (a), (c). (Draper, D. H.: Impression Procedure in Mucostatics, North-West Dentistry **26**:71 [April] 1947)
5. The teeth tend to migrate slowly forward and to erupt in an occlusal direction. (Davies, G. N.: Prevention of Malocclusion by Judicious Use of Space Retainers, New Zealand D. J. **48**:123 [April] 1952)
6. (a) greatest. (Accepted Dental Remedies, ed. 18, American Dental Association, 1953, page 95)
7. True. (Moore, T. E.: Compensating for Alloy Shrinkage, J. Prosth. Dent. **2**:554 [July] 1952)
8. (c) 10 times. (Rosen, Ralph: Plastics—Today's $64 Question, J. Missouri State D. A. **32**:230 [July] 1952)
9. Yes. (Grossman, L. I.: Handbook of Dental Practice, ed 2, Philadelphia, J. B. Lippincott Company, 1952, page 273)
10. True. (Nuckolls, James: A Review of Some of the Factors Concerned with the Etiology and Pathogenesis of Acute Erosion, J. Am. Coll. Dentists **19**:182 [June] 1952)

?

how many products used in Dentistry can you name, Doctor, that have been in use more than half a century and *still meet the exacting requirements of modern dentistry?*

one such time-tested product – if you'll forgive us for prompting – is Steele's Interchangeable teeth. The basic principle of Steele's teeth is exactly the same today as in 1903 when it was introduced. The teeth themselves, however, have been constantly improved – in esthetics – and in variety.

Steele's facings and Trupontic teeth continue to be universally accepted as the *modern* teeth – for all restorations of metal.

The Columbus Dental Manufacturing Co.

COLUMBUS 6, OHIO



LET'S LOOK AT T

Only Amm-i-dent has confirmed p

The following is a digest of all significant clinical work published on the dentifrice control of caries. . . . . .

1—PENICILLIN DENTIFRICE

PRO In a 2-year study of elementary school children, Zander[1] reported a 53.8% reduction in caries in the penicillin dentifrice group.

CON A 1-year study by Hill and Kniesner[2] with children of similar age actually showed a 5.7% average *increase* in carious surfaces in the penicillin dentifrice group; and Hill et al[3] in a 1-year study found only a 14.5% reduction.

EVIDENCE CONTRADICTORY

2—LOW-UREA AMMONIATED DENTIFRICE

PRO Kerr and Kesel[4] in a 2-year study with school children, reported that a low-urea ammoniated dentifrice effected a 12.4% reduction in caries.

CON Dirks et al[5] used a low-urea ammoniated dentifrice with school boys in a 1½-year test . . . concluded that it "had no effect on caries incidence."

EVIDENCE CONTRADICTORY

3—DENTIFRICE USED AFTER EATING

PRO After a 2-year test, Fosdick[6] reported that young adults who brushed their teeth with a dentifrice within ten minutes after ingesting food or sweets, had a 41% lower incidence of caries than controls of similar age who brushed their teeth only on arising and before retiring.

CON In a more recent report Fosdick[7] obtained the opposite result. Those brushing after eating had 29.6% *more* cavities than those who brushed with the same dentifrice only on arising and before retiring.

EVIDENCE CONTRADICTORY

4—SODIUM N-LAUROYL SARCOSINATE DENTIFRICE

PRO Fosdick[7] in a preliminary 1-year report on a group of young adults using a sodium N-lauroyl sarcosinate dentifrice presented no clinical data though this was available. A comparison of X-rays of limited areas of the mouths of test vs. control subjects showed 57% fewer carious lesions.

CON Forscher and Hess,[8] employing the sodium N-lauroyl sarcosinate dentifrice, reported that the test dentifrice did *not* prevent acid formation, and questioned the validity of Fosdick's acidity findings.

NO PUBLISHED CLINICAL DATA

5—SODIUM DEHYDROACETATE DENTIFRICE

CON No report on the effect on caries has yet been published.

NO EVIDENCE

References 1. Zander, H. A.: J.A.D.A. 40:589, 1950. 2. Hill, T. J. & Kniesner, A. H.: J. Dent. Res. 28:263, 1949. 3. Hill, T. J., Sims, J. & Newman, M.: J. Dent. Res. 32:448, 1953. 4. Kerr, D. W. & Kesel, R. G.: J.A.D.A. 42:180, 1951. 5. Dirks, O. B., Winkler, K. C. & Van Aken, J.: J. Dent. Res. 32:18, 1953. 6. Fosdick, L. S.: J.A.D.A. 40:133, 1950. 7. Fosdick, L. S.: Northwestern Univ. Bull. 54:20, 1953. 8. Forscher, B. K. & Hess, W. C.: J.A.D.A. 48:134, 1954. 9. Henschel, C. J. & Lieber, L.: J. Dent. Res. 28:248, 1949. 10. Gale, J. A.: The Dental Record 71:15, 1951. 11. Lefkowitz, W. & Venti, V. I.: Oral Surg., Oral Med. & Oral Path. 4:1576, 1951. 12. Gale, J. A.: The Dental Record 71:184, 1951. 13. Henschel, C. J. & Lieber, L.: Oral Surg., Oral Med. & Oral Path. 5:155, 1952.

THE RECORD:

published clinical proof of caries reduction

6 — HIGH-UREA AMMONIATED DENTIFRICE (AMM-I-DENT)

PRO With adults, Henschel and Lieber[9] reported a 37.5% reduction in caries incidence in the Amm-i-dent group after a three-year period.

PRO After a 1-year test with pre-school children, Gale[10] reported a 39.6% reduction in caries incidence in those using Amm-i-dent.

PRO Reporting at the end of the third six-month period of a long-range study with teen-age children, Lefkowitz and Venti[11] found a 50.9% reduction in caries incidence in the group using Amm-i-dent.

PRO In a 21-month report, Gale[12] showed that Amm-i-dent had reduced caries incidence by 32.5%.

PRO Compiling data over a 4-year period, Henschel and Lieber[13] reported a 43.6% reduction of caries incidence in the group using Amm-i-dent.

PRO A study recently completed among school children shows a significant reduction in caries by the use of Amm-i-dent (publication pending).

EVIDENCE UNANIMOUSLY FAVORABLE AND UNCONTRADICTED



The only high-urea ammoniated dentifrice—paste and powder

(Formula protected by U. S. patents)

AMM-I-DENT, INC., JERSEY CITY 2, N. J.

24-E

Amm-i-dent®

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Denture Occlusion

Q.—One of my patients, who has worn full dentures more than three years, has trouble with spots on the lower ridge. At first, I thought these spots were caused by the ill-fitting dentures, so I relined them and they seem to fit. The occlusion appears correct and feels well balanced to the patient, but he constantly returns with a sore spot. I stone the spot on the denture, first circling the sore spot with indelible pencil, then transferring to the denture, but the next week when he returns there is a sore spot on the other side with slight whiteness around the spot as if the tissue had been burned with some caustic. There is no high bony point under the soft tissue because the ridges are smooth after three years.

I have used articulating paper and checked for occlusion high spots and there seem to be none. There is good continuous pressure all around.

I am at a loss as to what causes these spots. Do you think it could be a systemic disease?—D.H.P., Louisiana.

A.—I have provided comfort in a number of similar cases by careful and patient reapplication of disclosing wax, thus perfecting and balancing the occlusion more accurately than it is possible to do with carbon paper. Cover the occlusal surfaces (usually of the lower denture only) with melted red disclosing wax. Lubricate the upper occlusal surfaces with saliva, ask the patient to close very gently, and tap on the back teeth. The idea is to stop the closure the instant that one or more teeth cut through the wax to contact porcelain against porcelain. Remove the denture and grind the spot or spots and repeat application of wax and closure until bearing is really uniform in centric and in all excursions. Remove occlusal wax by wiping with cleansing tissue and finally with warm water and soap on a denture brush.

Next cover the tissue bearing surface of the denture with melted ivory disclosing wax and have the patient close with masticating pressure, remove denture and grind it with a large round bur where the wax has been pressed out, baring the acrylic. Repeat this procedure as many times as necessary to provide a uniform bearing of denture against supporting tissue. This is a more accurate way of relieving pressure over tender spots than the indelible pencil method. All relieved surfaces should be ground as smooth as possible and polished before dismissal of the patient.—V. C. SMEDLEY.

Divide Stress

Q.—I have a patient, a woman about forty years of age, with a low threshhold of pain, who came to my office



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with the complaint that because of apparent slight loss of hearing she had visited an ear specialist who suggested she visit a dentist. An examination showed a considerable number of restorations and bridgework. In addition, the upper second and third molars on the right side were missing and all three molars on the upper left and lower right and left were missing and had been for a number of years.

After full mouth roentgenograms and study models were made and following a consultation with her ear specialist, partial upper and partial lower vitallium dentures were made with onlays and clasps on the four lower bicuspids. It was difficult for the patient to become accustomed to these.

Recently, hot and cold bothered the lower right second bicuspid for several weeks but the pain disappeared.

Examination revealed some caries on the distal surface. I have showed the enclosed roentgenograms to several exodontists. Some say there is infection and to extract. Others say not to, that the condition is just a thickening of periodontal membrane due to the load carried by the tooth. I am inclined to agree with the latter. The tooth reacts vital. May I have your opinion?—A.D.S., California.

A.—Since this tooth now responds normally to vitality tests, I would say that the thickened periodontal membrane does not indicate infection. It is often advisable when supplying the molars on such a partial denture to provide double clasps for anchorage, thus dividing the stress between all four bicuspids instead of just two.—V. C. SMEDLEY.

Paralysis After Injection

Q.—I had an unusual experience with a local anesthetic and would like your opinion on the cause of the peculiar reaction. My patient was a girl, 18 years old, and in perfect health. I had used procaine on her many times before with no unusual reaction.

I gave a lower left mandibular block and evidently hit a vein. The patient's face almost immediately became cherry red. Her vision was obscured and her face became puffy and almost like an edema, especially under her eyes. She complained of severe headache, nausea and said she was going to faint. However, she did not faint, and in 15 minutes the main symptoms had disappeared. The anesthetic worked fine, and I completed the restorations. She still had the headache when she left.

Next morning the patient's mother called to tell me that the girl had a terrific headache and her right shoulder, arm and hand were paralyzed and she could not even lift them off the bed. In the afternoon, the condition was the same, and a physician was called. His explanation was that somehow the procaine had reached the brain and had caused an irritation to the portion which supplied motor nerves to the right arm. He gave her codein and acetylsalicylic acid.

The paralysis and headache were not gone until four days after I gave the injection. Then the patient made a complete recovery and has been all right ever since.

I am anxious to know if you have ever had a similar occurrence in your practice and how it can be explained.—H.E.M., Washington.

A.—Let me say that the type of anesthetic solution probably was not responsible per se.

It is not uncommon to have hematomas, emphysemas, or semi collapse when an anesthetic is inadvertently injected into a blood vessel. Considering that anesthetic injections are more or less blind

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and that the jaws have a rich blood supply, it is surprising that blood vessel walls are not penetrated more often.

It is said that the trigeminal nerve has synapses with 22 other cranial nerves, so it is not surprising that pain in a branch of the trigeminal should have far reaching and inexplicable effects. We have had cases of paralysis of the eye following a mandibular block.

Once I was setting a bridge with the posterior abutment being a class II inlay in the left mandibular second molar. The minute I pressed the bridge to place there was a sharp pain in the molar and in the left arm followed by a partial paralysis of the left arm, which fortunately lasted only an hour or so. Investigation disclosed that the cement under the inlay had broken through a thin dentine wall into the pulp. Note, the trouble in the arm in my case was on the same side as the traumatized inferior dental nerve and was immediate, while in your case the trouble with the arm was on the opposite side and delayed many hours.

You naturally feel disturbed about the train of events following the mandibular nerve block for your young patient, but you should not feel that these events were the result of lack of skill or care on your part in making the block.—GEORGE R. WARNER.

Gingivitis

I am taking the liberty of commenting on your discussion with E.F.H. on gingivitis resulting from dilantin.

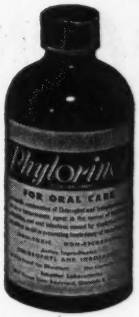
Surgery by itself has seldom resulted in permanent relief from the dilantin hyperplasia. I have found that relief will be temporary at best. On the other hand, my colleagues and myself have been successful in restraining this tissue by constant massage. In most severe cases, the use of both surgery and massage may be called for; thorough prophylaxis and subgingival curettage to be instituted, too.

I feel that a wise plan of procerure for E.F.H. to follow would include three steps:

1. Gingivectomy to eradicate existing pockets due to proliferation.
2. Thorough curettage and polishing of exposed root and crown tooth surfaces.
3. Instruction in use of hard toothbrush and interproximal stimulator according to modified Charter's technique. Massage in this manner at least four times daily. This can be accompanied by use of rubber cap stimulator (denticator) several times daily.

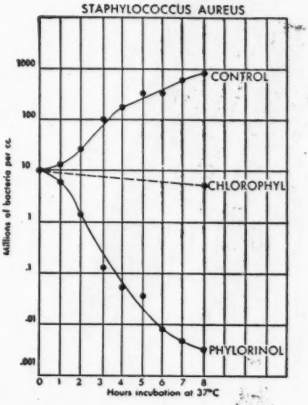
None of these procedures should interfere with orthodontic measures that E.F.H. may institute, although tongue biting may severely interfere with orthodontics.—SHELDON J. ROSS, D.D.S., 5 East 57th Street, New York, New York.

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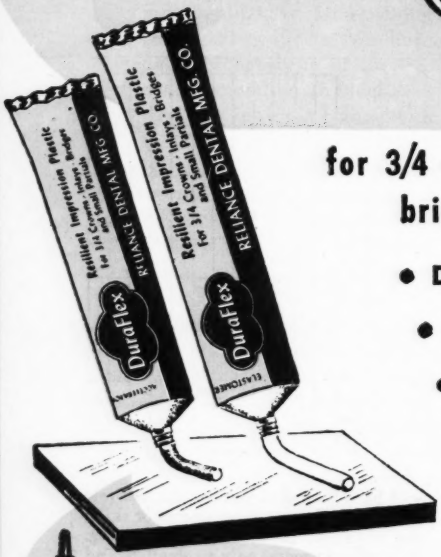
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"Oh, I'm sorry," she twittered. "I was looking for the fire escape."

As she continued her search, she heard the pad of bare feet behind her and a shout made her turn. It was the gentleman, clad in nothing but a bath towel.

"Wait a minute!" he gasped. "Where's the fire?"

★

Bride: "I am sorry, Egbert dear, but that old butcher cheated us."

Egbert: "How so, Darling?"

Bride: "The old meanie sold me a turkey that didn't have any stuffing."

★

Prof.: "Why aren't you taking notes?"

Stud.: "I don't have to. I've got my grandfather's."

★

Private: "The Sergeant has a wide acquaintance in town."

Corporal: "Yes, I saw him with her last night."

★

"I would like some alligator shoes."

"What size does your alligator wear?"

★

A pedestrian is a man who has two cars, a wife and a daughter.

★

Professor: "Why are all your test answers in quotation marks?"

Student: "Just a courtesy to the man on my left, sir."

Boy: "Darling, I could sit here and do nothing but look at you forever."

Girl: "Yeah, that's what I'm beginning to think too."

★

Stephenson: "The Penningtons are so quiet tonight. Is there anything wrong?"

Jefferson: "No, they're always that way. When he proposed he just held up a diamond ring and said, 'Eh?' and she looked at it and said: 'Uh-huh.' "

★

New Hubby: "If I were to die would you marry again?"

Movie Blonde: "You funny man! What gives you the idea I'll wait that long?"

★

Jake: "That's a pretty dress you have on."

Mary: "Yes. I only wear it to teas."

Jake: "Whom?"

★

Doctor: "I would advise you, madam, to take frequent baths, get plenty of fresh air, and dress in cool clothes."

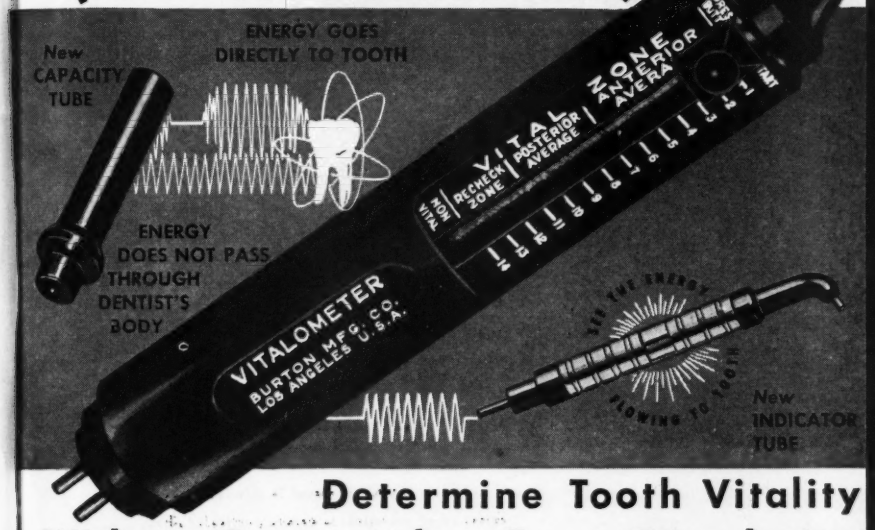
Husband (an hour later): "What did the doctor say?"

Wife: "He said I ought to go to Miami and then to the mountains; also, that I must get some new light clothes at once."

★

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  In dis land,
I get a divorce
  From my old man—
I had to laff
  At de court's decision;
They gives him de kids,
  And the kids ain't hisn.

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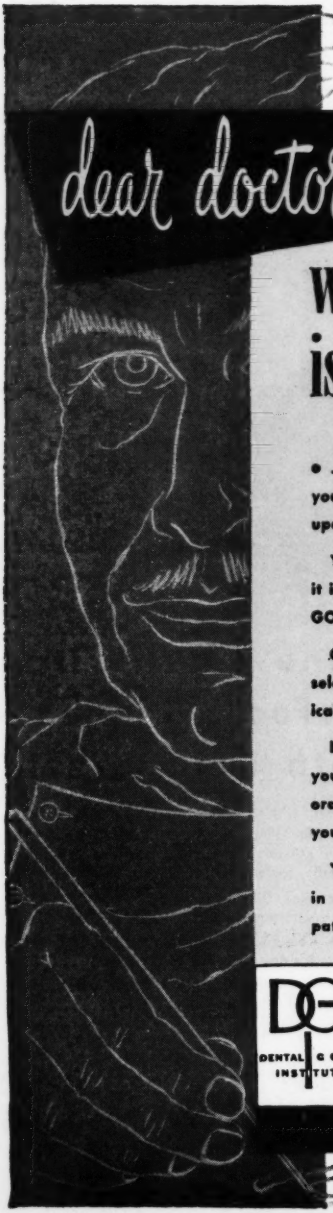
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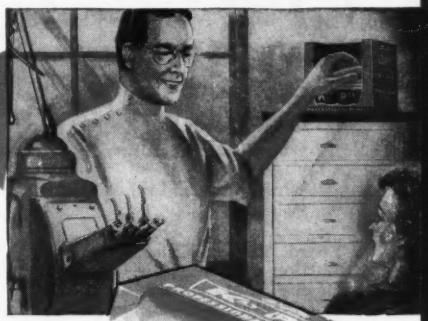
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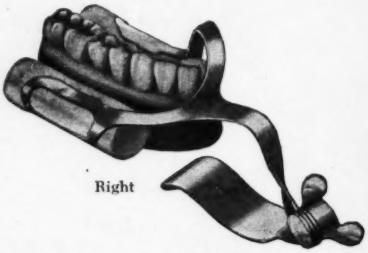
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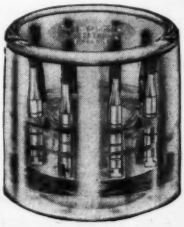
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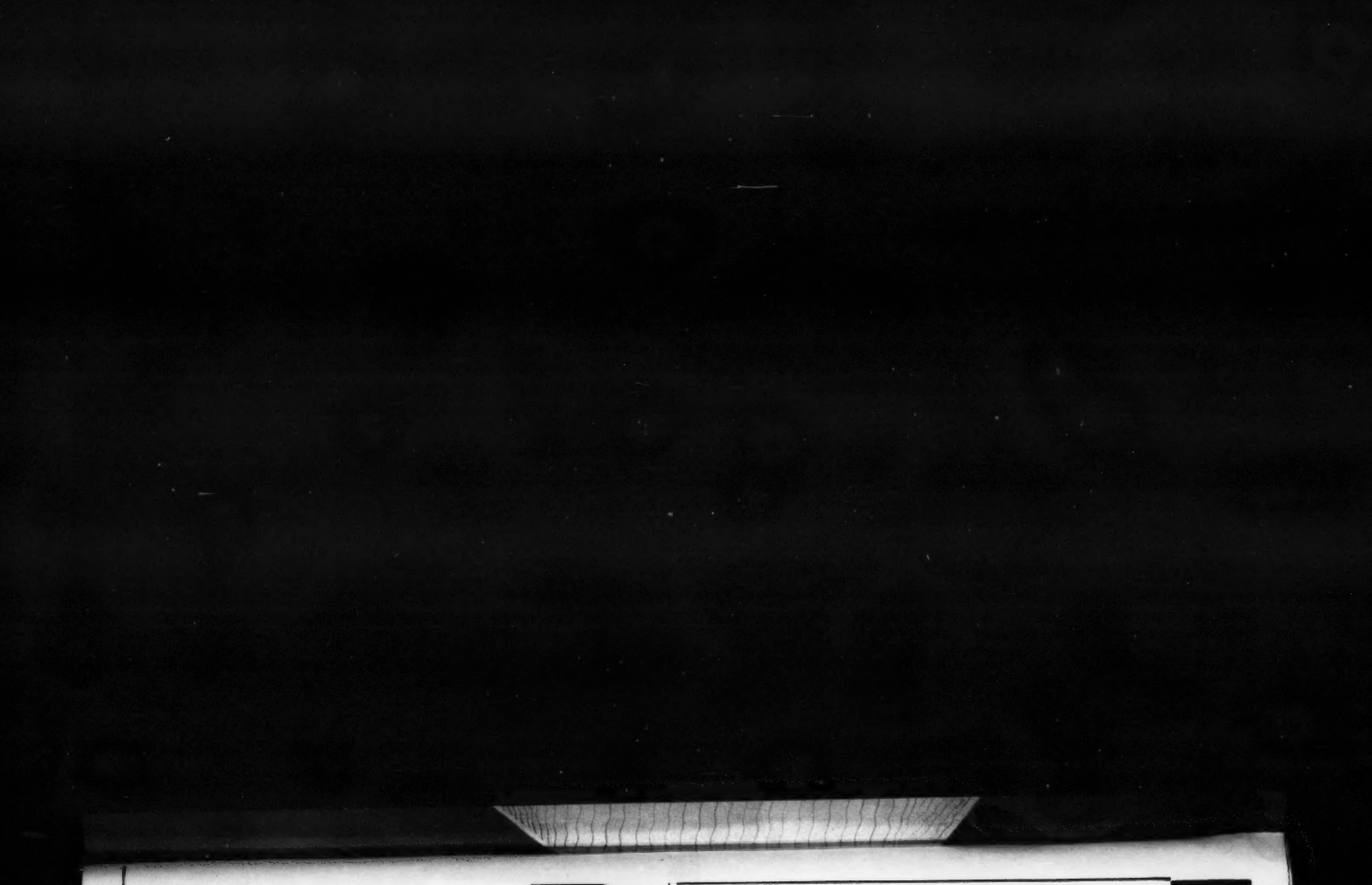


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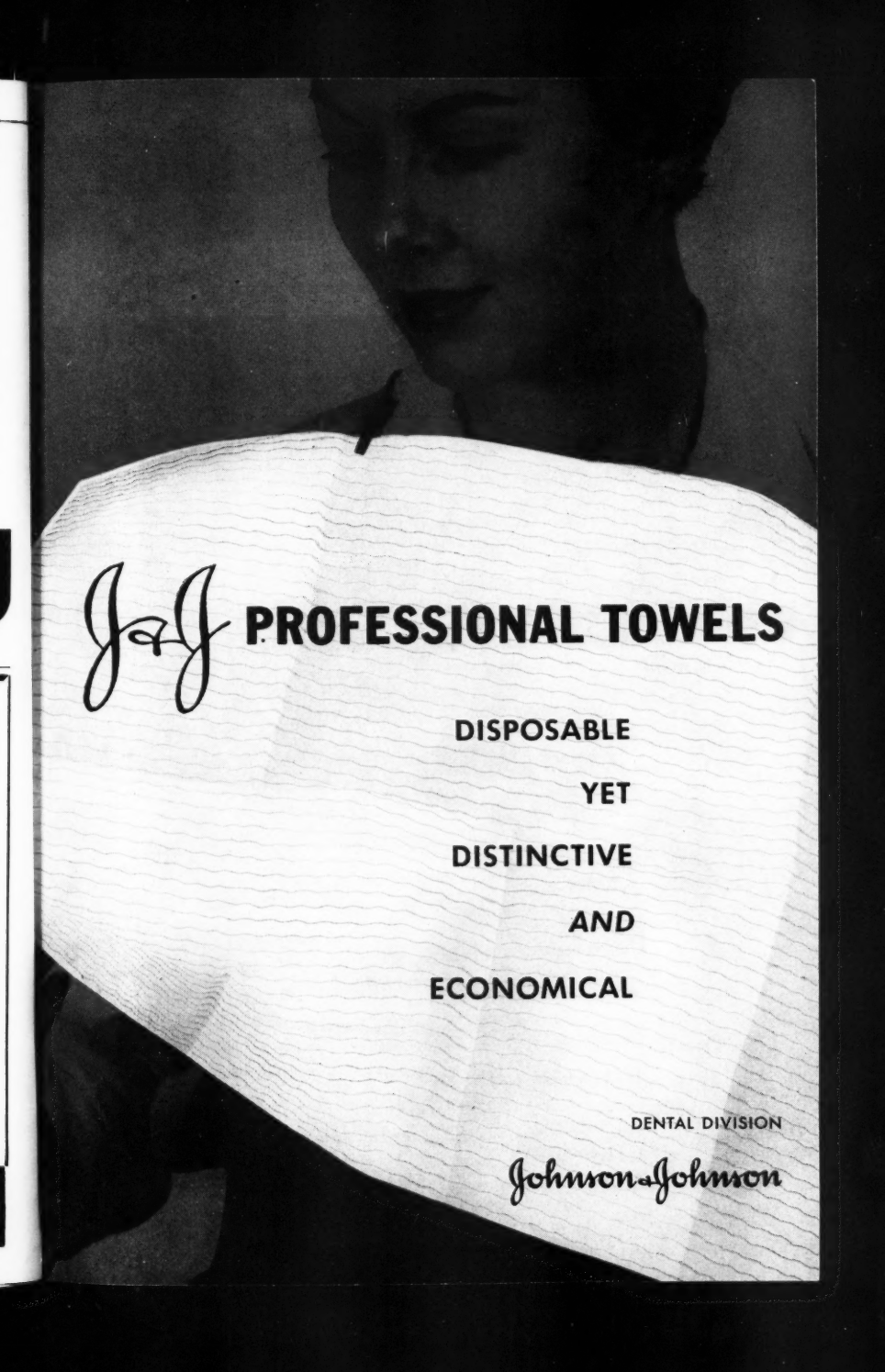


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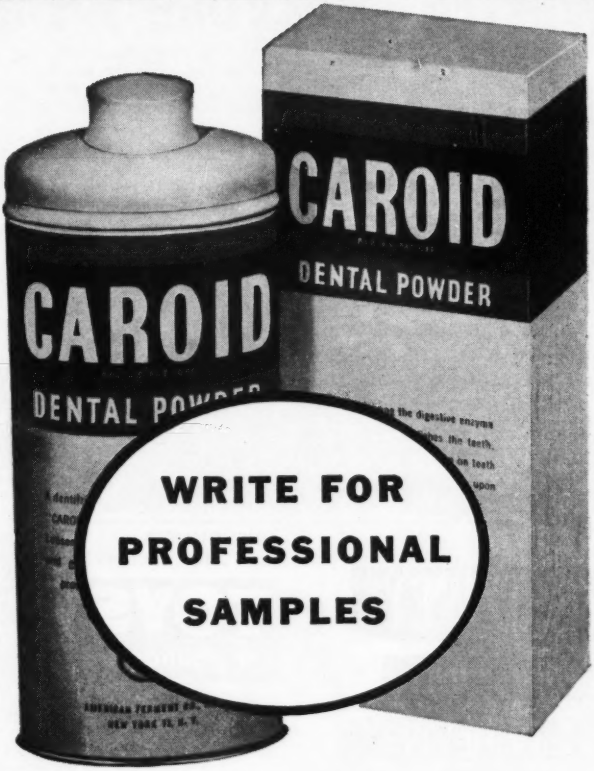
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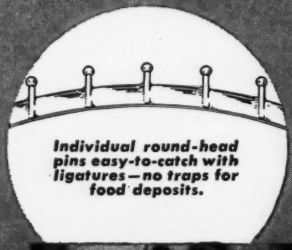


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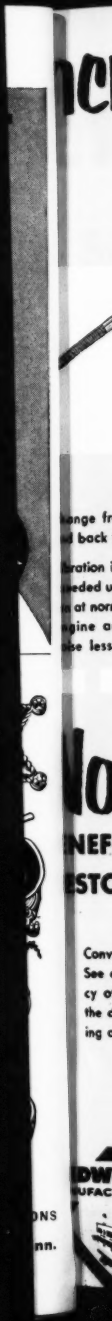
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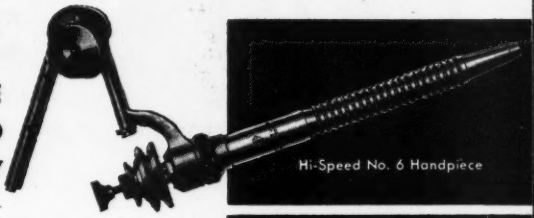


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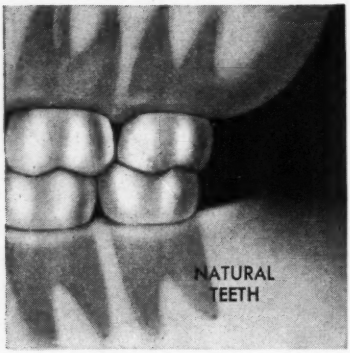
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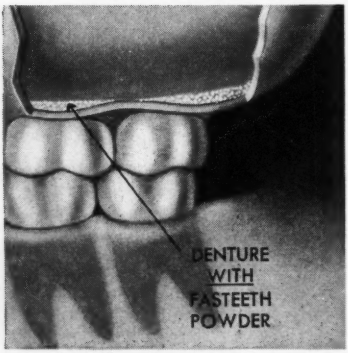
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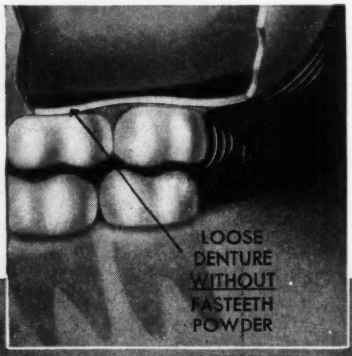


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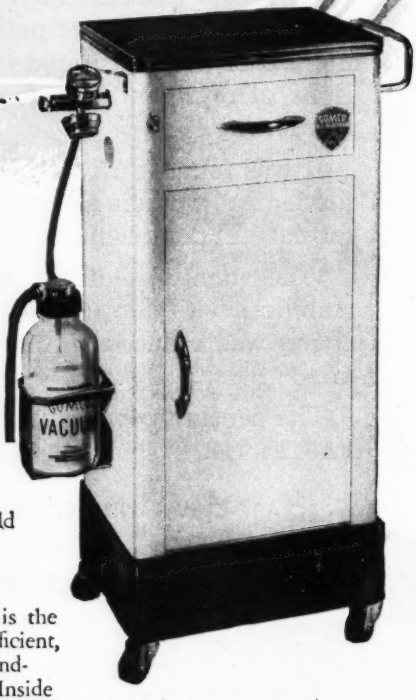
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1. Manly and Vinton—J. Prosth. Den. 1, 578-586 (1951)

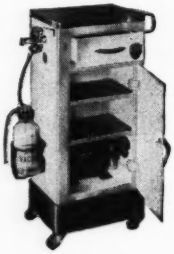
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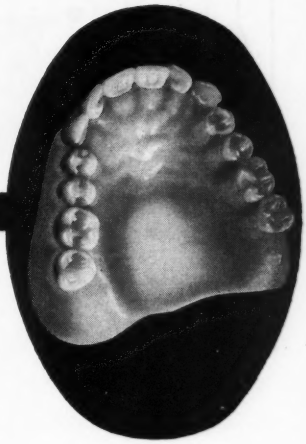
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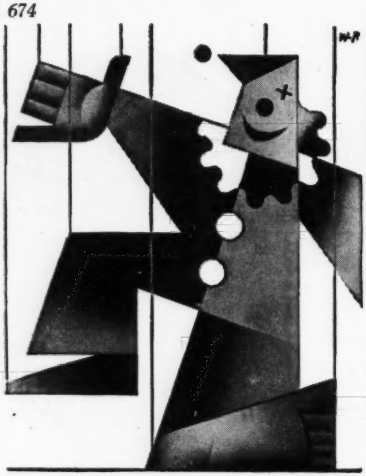
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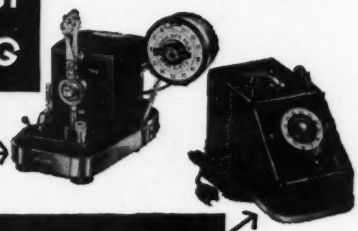
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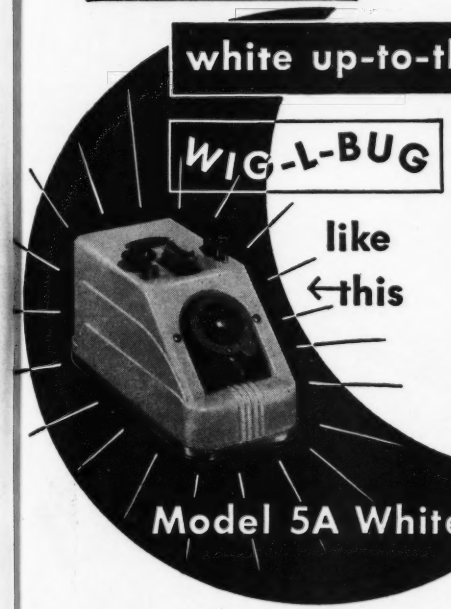
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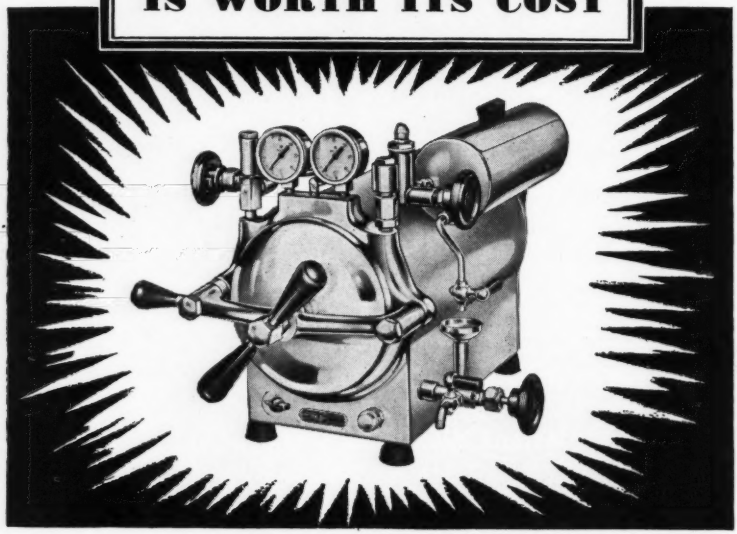
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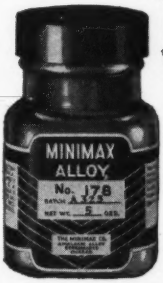
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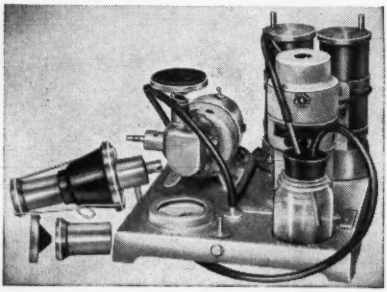
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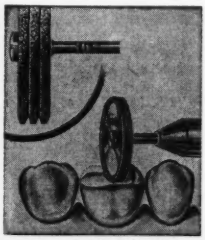
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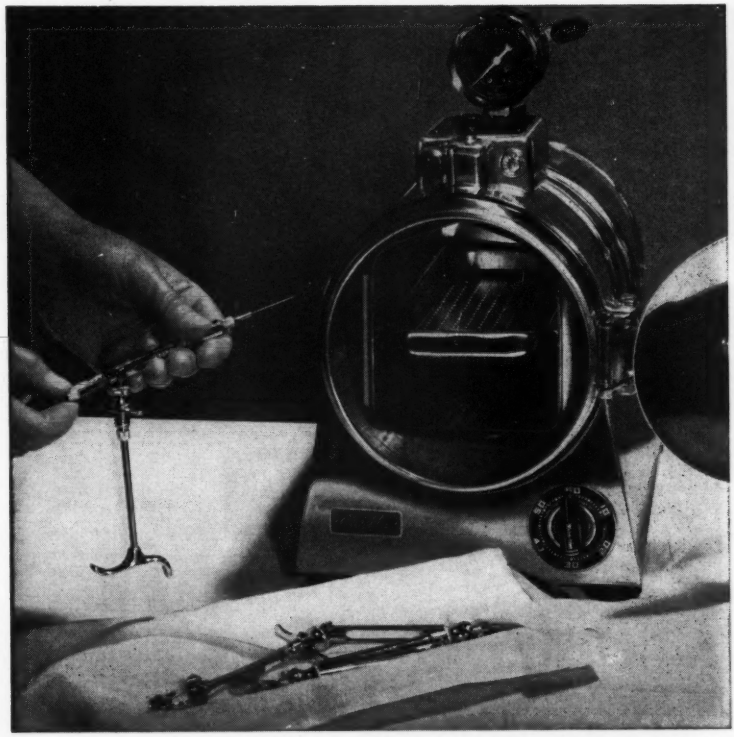
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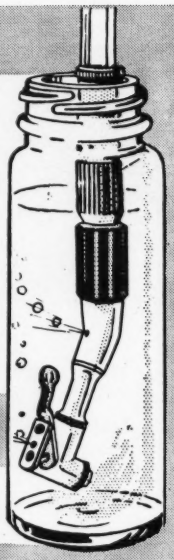
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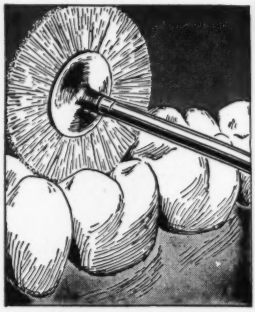
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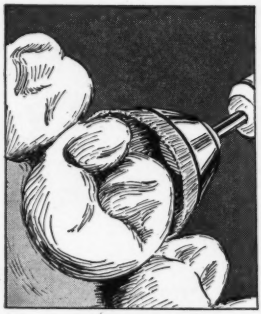
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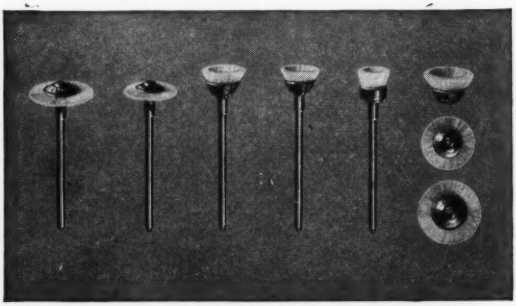


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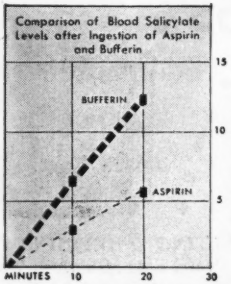
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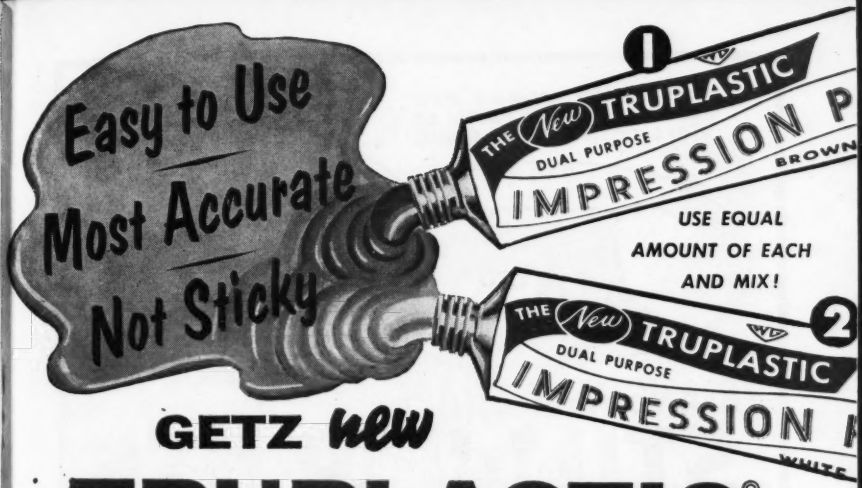
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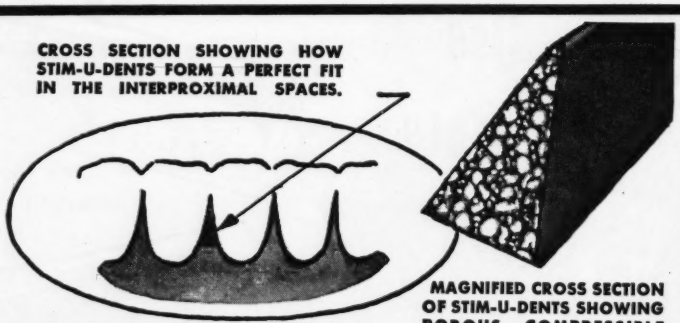
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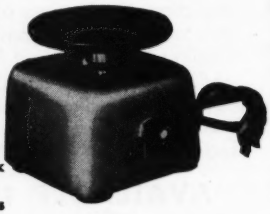
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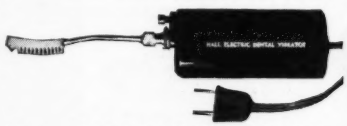
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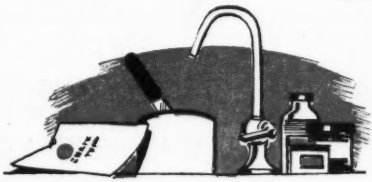
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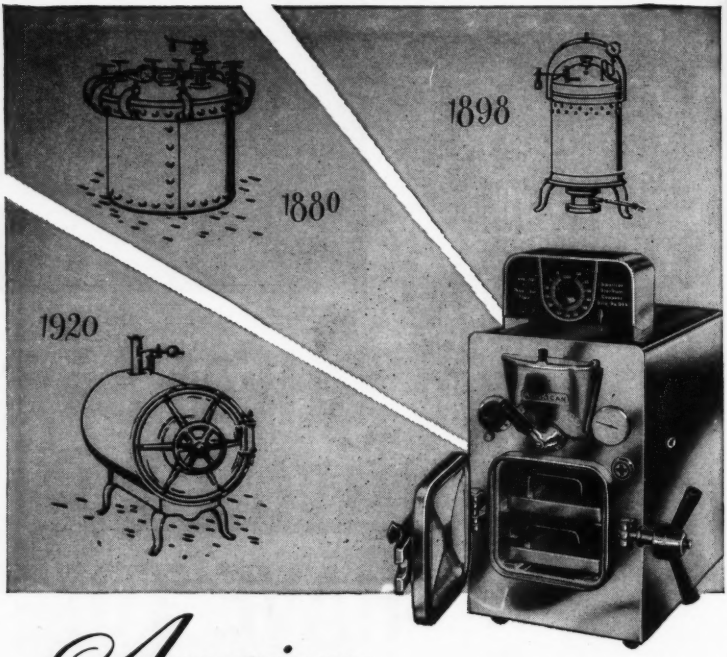
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Fig. 1

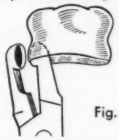


Fig. 2



Fig 3

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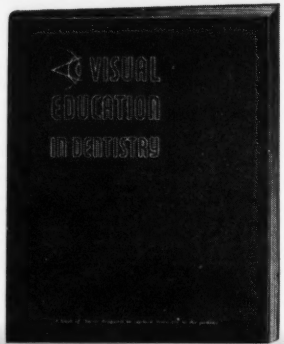
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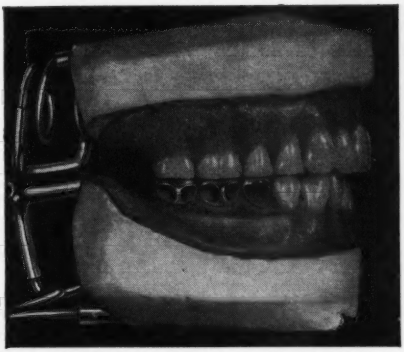
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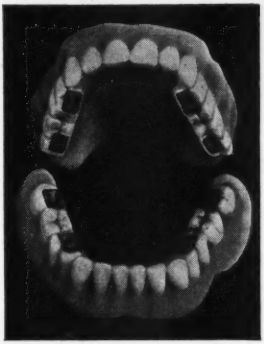


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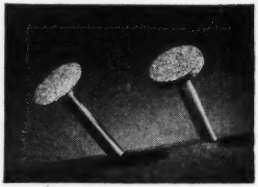
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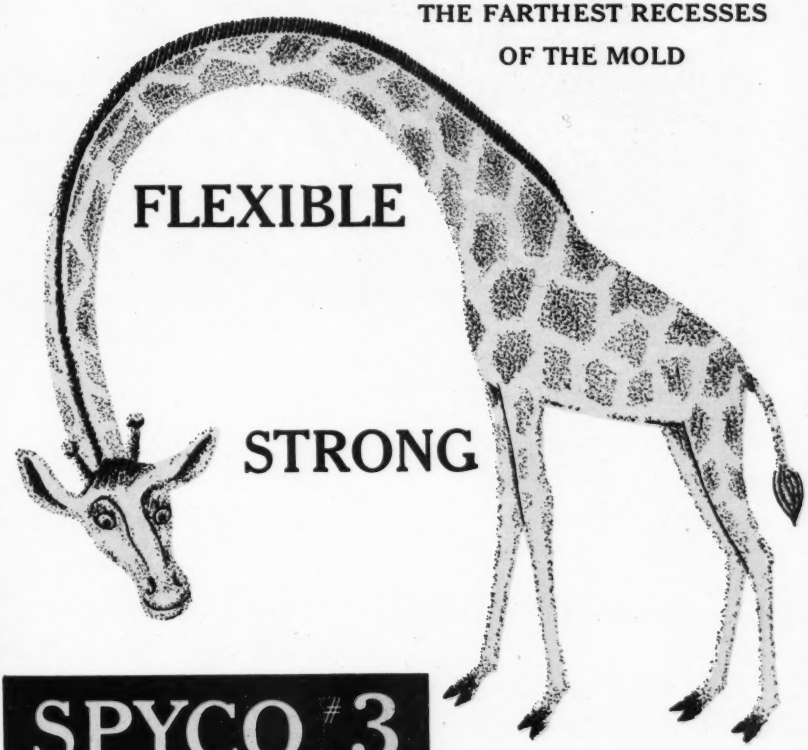
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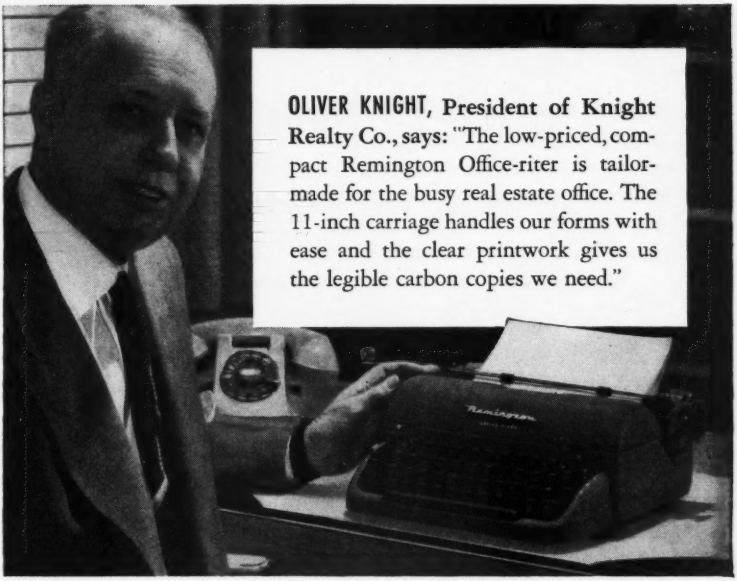
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Clinical Evidence Available

But now, *the results of clinical tests begun over a year ago* by a research team from leading dental colleges have been made available. They show that New Colgate Dental Cream with Gardol (Sodium N-Lauroyl Sarcosinate) showed the greatest reduction of tooth decay in toothpaste history.

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With Clinical Proof

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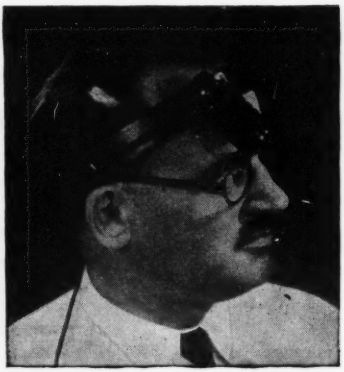
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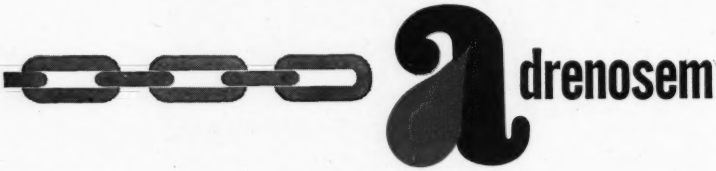
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*Sherber, D. A.: The Control of Bleeding, Am. J. Surg. *86*:331 (Sept.) 1953.



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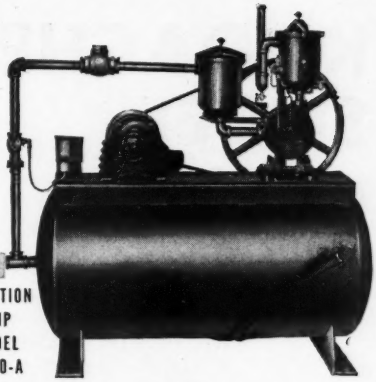
- *preoperatively* to control oozing during surgery and provide clearer operative field: one to two ampuls (5 to 10 mg.) every two hours prior to surgery for two doses.
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- to control *active bleeding:* One ampul (5 mg.) every two hours until bleeding is controlled; frequency of dose may then be diminished.
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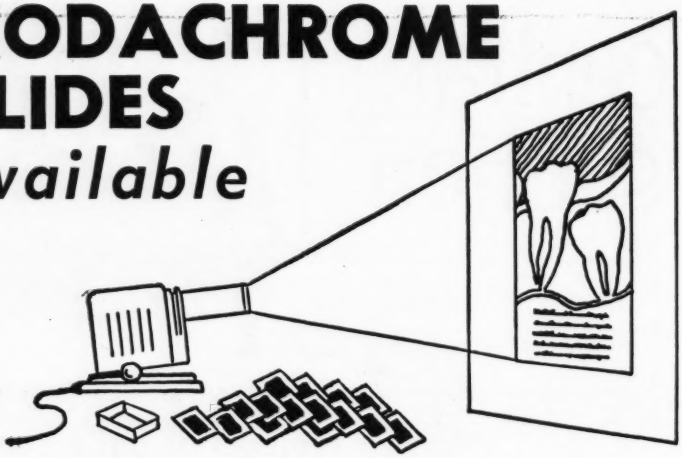
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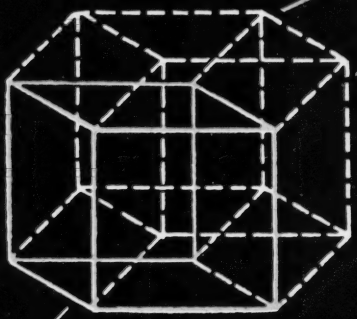
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†Bragdon, C.: A Primer of Higher Space, New York, Alfred A. Knopf, 1923, Plate 1.

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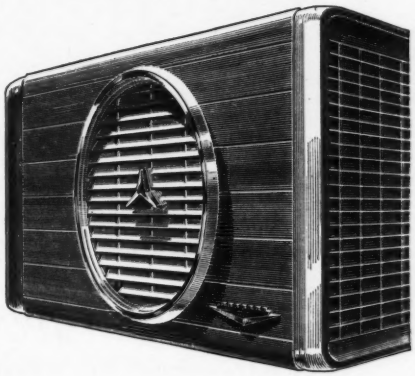
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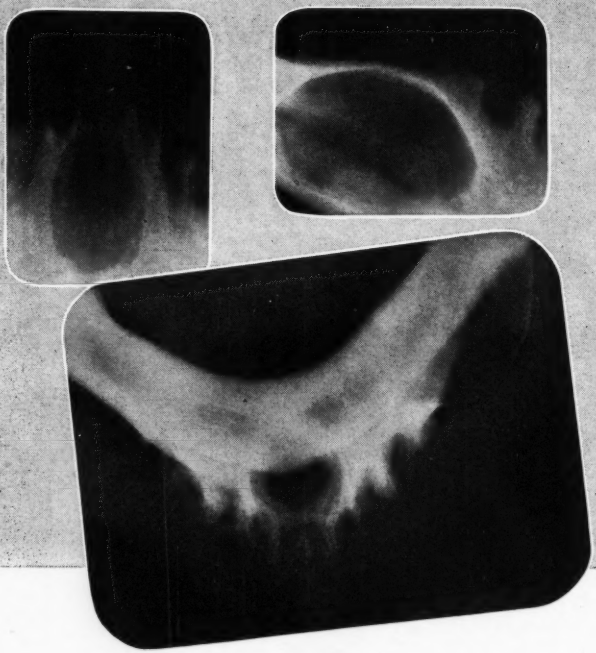
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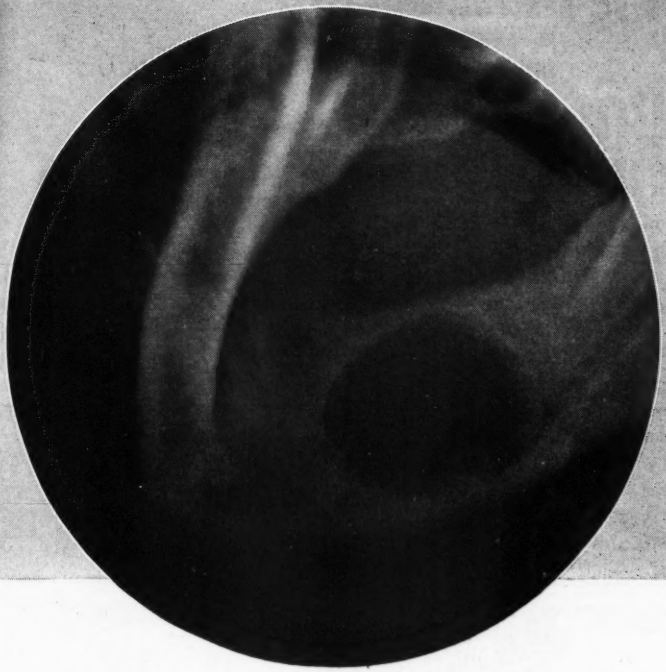
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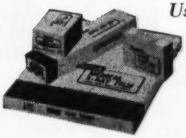
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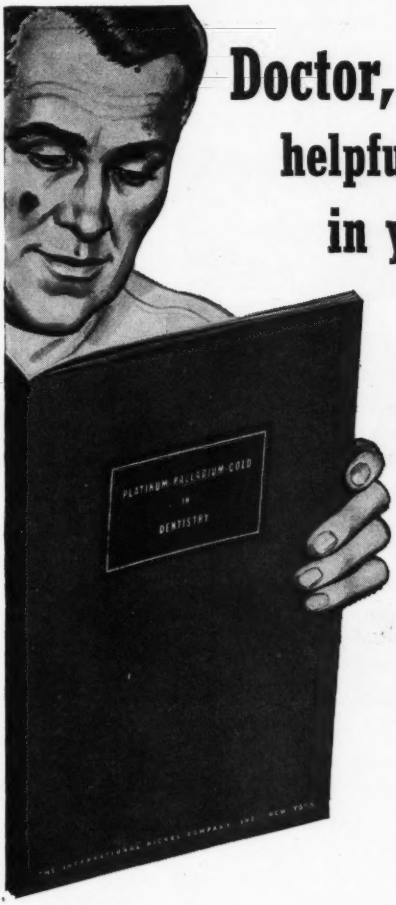


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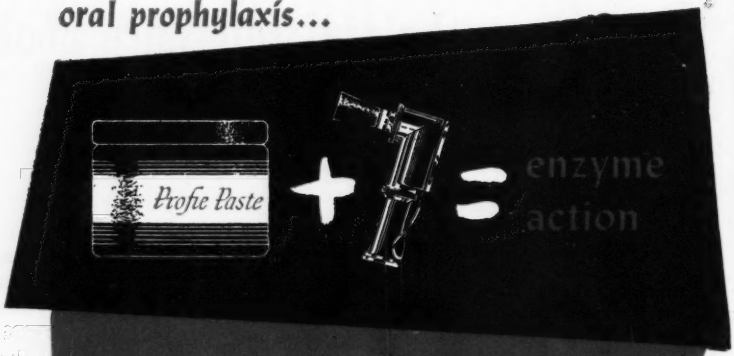
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why risk these HAZARDOUS TEMPERATURES created by frictional heat of rotating cutting instruments

The following chart is based on data from a study recently conducted by the School of Dentistry, University of Michigan, Ann Arbor, Mich.*

TYPE BUR	COOLANT	DEGREES F. RISE AT 1 LB. PRESSURE			
		2000 RPM	4000 RPM	6000 RPM	10000 RPM
#37 Steel	None	37°	60°	78°	112°
	Air Only	17°	25°	33°	43°
	Air-Water Spray	4°	7°	9°	12°
#37 Tungsten Carbide	None	26°	42°	57°	84°
	Air Only	17°	25°	33°	45°
	Air-Water Spray	3°	6°	9°	12°
#701 Diamond	None	21°	30°	39°	52°
	Air Only	9°	14°	18°	25°
	Air-Water Spray	2°	4°	7°	9°

★ Report Published in New York Journal of Dentistry, 22:147-157 (April) 1952

NOTE: Degrees F. represent temperature rise above initial temperature of operating area. For example, at intermittent operation of 2 seconds cutting and 1 second rest, *without coolant*, a #37 steel bur at 1 lb. pressure and 6000 rpm increases the temperature 78° F. Accepting 90° F. as the initial temperature of the operating area, the cutting operation, therefore, brings the temperature in the tooth structure up to 168° F.

It can be readily seen that, even at minimum operating speeds and pressures, rotating cutting instruments create excessive heat, with needless risk of serious damage to tooth tissue and pain to the patient.

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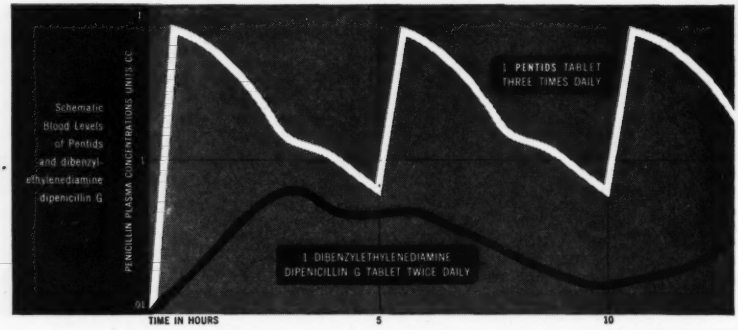
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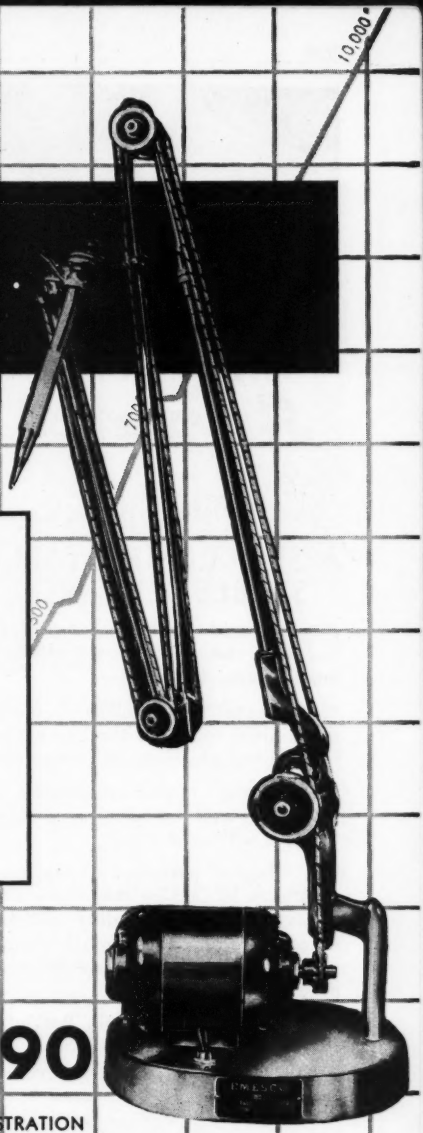
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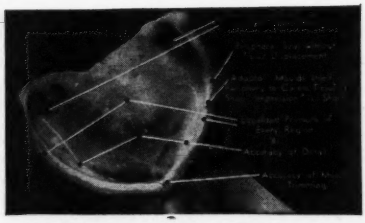
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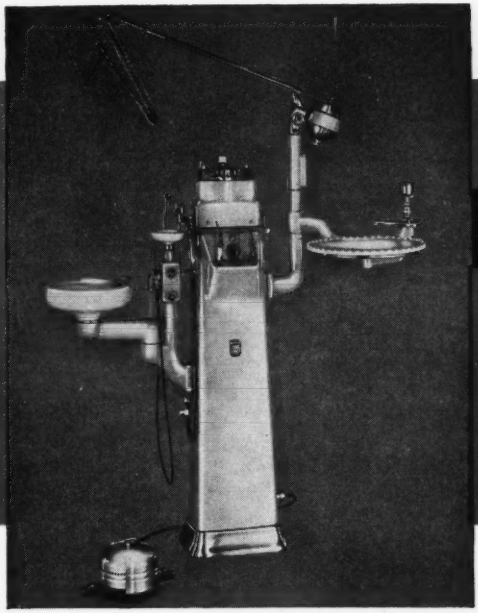
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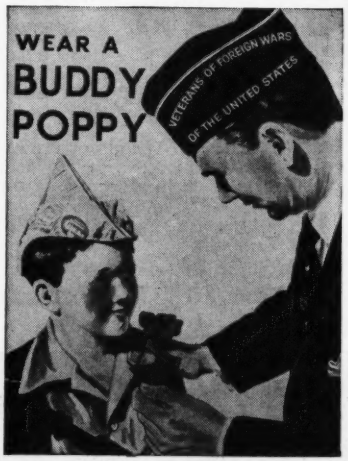
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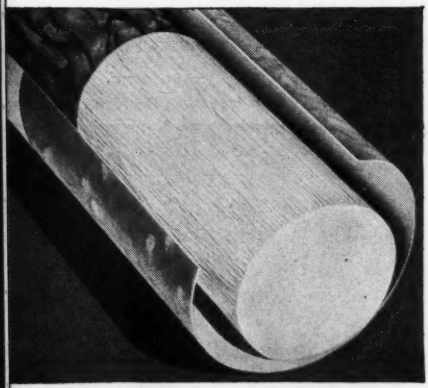
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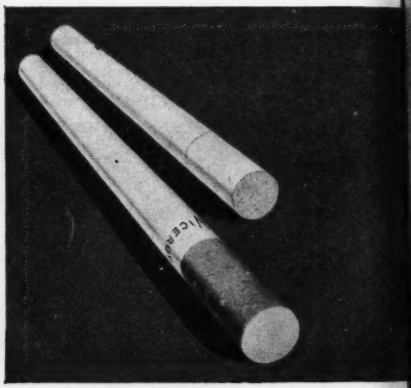


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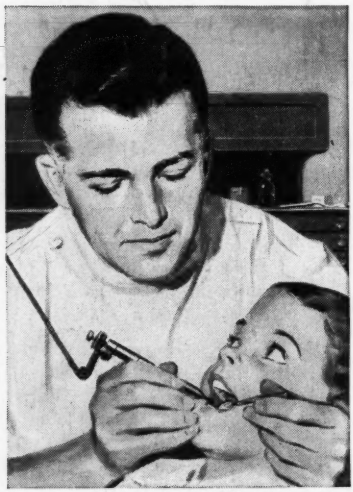
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